TONY C. PAYNE 06-0085 RKD

ase Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

	1	Unpend item#2	State of Ma	r Mt. (8) aryland /		7/06 T artment <i>tificate</i>			nd Mer		-	006) [0050	
	1	Registrar Decedent's Name (First, Middle, Las	<i>st</i>)		001	incate	- 01 1	Jean	2	Date of Dea	Reg. No.			3. Time of D)eath
Physician	r	Fony C. Payne								Month ANUAR	Day	, 200	ear 6	7:34P.	
/Medical Examiner		a. Facility Name (If not institution, give	street and number)			4b. City, 1	Town, or	Location of		11101111		County of		7.10.12	
LAGITITICI		336 S. PAYSON STR	EET			BAL	TIMO	RE							
Funeral Director	5	. Social Security Number 215–88–8736 9. S		e (In yrs. last 39	birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min. 8.	Date of Birt (Month, Day 1 — 1 4	h Y <i>Year)</i> 1 – 6 6	9	Birthpl Coun MD	lace (State or atry)	Fore
f show lies at	1	Jsual Residence of Decedent Oa. State MD 10b. County		10c. City, T Balt	own or Lo	re							1	0d. Inside City	
3a or 28e at the notil	1	Oe. Street and Number 336 S. Payson S	St.			10f. Zip 212	Code 223				10g. Citi	zen of Wh	at Coun	ntry?	
ygiene. ser than "natural", or items 23e or 28e-f show it, its Missical Examinar must be notified at Completed by Funeral Director	1	1. Marital Status XX Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 Y I If Yes, Give Year or Dates:			Was Deced if Yes, spec	* *	ispanic Origin, Mexican Specify:	jin? (Specif , Puerto Ric	y Yes or No an, etc.)	•	14. Race - Black, Specify:	White,		
"naturalization	-	15. Decedent's Er (Specify only highest grade) Elementary/Secondary (0-12)	ducation ide completed) College (1-4or 5	5+)	6a. Dece (Give life.	dent's Usua kind of wor DO NOT us	I Occup rk done d se retired	ation during most ()	of working		16b. Ki	nd of Busi	ness/Ind	dustry	
other than went, the Miles Comp	-	6th				Labo	ore					stru		ion	
d out	3	17. Father's Name (First, Middle, Last, Melvin Bennet						Cora	Lee	Payr	ne				
BEE	- 1	19a. Informant's Name/Relationship (Joseph Payne	Type, Print) (uncle)	1		_				Route Numbe klyn				21225	
ent of He nt: If item ry or oth		20a. Method of Disposition 1√ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	Removal from State	20b. Plac cem Trir	e of Disponent etery creating nity	osition (Name matory or of Ceme	ne of ther place ete:	ry 1	-10-	- 1		cation - Ci Idalk			
Depertment of Health a important: If item 27 leany injury or other tra-		21. Signature of Funeral Service Lies		1						ley (
Vicion and Asicion	2	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as Due to (or as Due to (or as d.	a consequer	nce of):	æ									
death. sctor: After this certificate has been signed by the ettending phy y the funeral director, page 2 should be detached for use as the fileation: To Be Completed by Physician/Medic		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal de	ath 3	□Ectopic pr □ Other (sp		′				23d. Date Monti		-	'ear
should be deta	D A	Part II. Other significant conditions Human Immunodeficien	-		ng in the u	ınderlying c	ause grv	en in Part I.			obacco (ute to t	he cause of de bably 4 Dru	
ate has bee page 2 shou	naiduio								-	24a. Was auto pend 1 Yes	psy pmed?	pri	or to co	opsy findings a emptetion of ca	
certificate rector, pag	D D	25. Was case referred to medical examiner?	Hospital:				10#		of Death (Check only		3.7		COUNTE	_
this cral dire		1 XYes 2 No 27. Manner of Death	1 Unpatio	ent 2 EF	VOutpatie		1	4 1110		d. Describe				»SCENE	
within 24 hours effer death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page Madical Certification: To Be Com	eruncation	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not lead to determine to	28e. Place of In		Injury	М		rk? Yes 2□	No		Street a	nd Number		al Route Numb	ber,
within 24 hours effer death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) 1 Certifying P 2 Medical Exa	hysician: To the best miner: On the basis of and manner si	of examination	edge, dea n and/or ii	th occurred nvestigation	at the ti	me, date an opinion, dea	d place, an th occurred	d due to the at the time,	cause(s date an) and man d place, ar	ner as s	stated. to the cause(s))
within 2 To the complete	Me	29b. Signature and title of certifier	HALDOII	Lina	L	290		se number				ite signed		Day, Year)	
		30. Name and address of person who	completed cause of	death (Item 2	23a) (Type	, Print)	PENN	I STRE	ET BA	LTIMOI	RE M	ARYLA	ND 2	21201	
	- 1	31. Date filed (Month, Day, Year)	32. Begist	trar's Signatu											

			For State Registrar	State of Maryland		rtment of He tificate of D		, ,	iene .g. No. 006	00502
	Physici /Medic		1. Decedent's Name (First, Middle, Las Elsie Jean Park	-				2. Date of Deat Month	Day Yee	06 8:20 PM
	Examin	er	4a. Fecility Name (If not institution, give Battimore Vashim 5. Social Security Number 6. Social	g-ton Medical	Conter	4b. City, Town, or I	Burnie	8. Date of Birth	Anne A	rundel
	Funeral Director			□ M 2只F 86	Yrs.	Months Days	Hours Min.	Month, Day, July 18		irthplace (State or Foreign Country) ustralia
	e Marylan la-f show	ctor	10a. State 10b. County MD Anne Art		Town or Lo					10d. Inside City Limits 1 ☐ Yes 2√ No
	3a or 28	I Dire	10e. Street and Number 17 Pinkney Street	E		10f. Zip Code 21401		1	Og. Citizen of What G	
920	filed within 72 hours efter death with the Maryland Hygiene. other than "natural", or Itama 23a or 28a-f show ent, the Medical Exercit artimatics neithed at	by Funeral Director	11. Marital Status unk 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2♥□ No If Yes, Give Year or Dates:	11	Vas Decedent of His Yes, specify Cuban ☐ Yes 2 ☐ No	panic Origin? (Spe., Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)		nerican Indian, nite, etc.
Maryland 21215-0036	vithin 72 ho ne. han "natur e Medicul	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give life. L	ent's Usual Occupa kind of work done di OO NOT use retired)	ıring most of workir	ng .	16b. Kind of Busines	
nd 2	oe filed v al Hygie d other t	Be Co	12 17. Father's Name (First, Middle, Last)			<u>registere</u>	nurse 18. Mother's Name	(First, Middle, I	healt Maiden Surname)	h
aryla	should be find Mental In marked of	10	James Alexander 19a. Informant's Name/Relationship (7)		19b. Mailin	g Address (Street a	Sybil Ma and Number or Rura		On r, City or Town, State	, Zip Code)
Baltimore, Ma	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Itema 23a or 28a-f show any injury or other traumatic event, the Medical Examinatinal transitional and once.		Baltimore Washing 20a. Method of Disposition 1 Burial 2 Cremation 3 C 4 X Donation 5 Other (Specify	Removal from State 20b. Pla	ace of Dispo	Hospital sition (Name of natory or other place	, D		20c. Location · City	
Balti	permit. Departri Importa any inju		21. Sign pure of Euneral Say ce Licen	Wade Virector	St	Name and Address ate Anato	my Board		Baltimore	Street
	Fnysician /Medical		23a. Part1. Enter the disease, or com- hock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line. a	Do not enti	er the mode of dying	, such as cardiac o	respiratory arro		Approximate Interval Between Onset and Death
8760,	taw requires that the deeth certificate be executed to a second as been signed by the attending physicien and 2 should be detached for use as the burial-transit to a should be detached for use as the should be a shou	dical Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Oue to (or as a consequence) C. Due to (or as a consequence) d.	ance of):					
.O. Box 6	that the deeth certific ed by the attending p detached for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3□	Ectopic pregnancy Other (specify)			23d. Date of o Month	delivery Day Year
Q.	w requires that the bean signed by should be detact	by	Part II. Other significant conditions of	contributing to death but not resu	lting in the u	nderlying cause give	n in Part I.			to the cause of death? Probably 4 Prophysical Probably 4 Prophysical Probably 4 Prophysical Probable
Vital Records,	The ate h	Completed						24a. Was a autops perform	sy prior t	autopsy findings available o completion of cause of ? es 25 No
	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 E	ER/Outpatier	t 3 DOA Othe	26. Place of Death		ence 6 Other (S	pecify)
Division of	ing Yfter une	ation: T	27. Manner of Death 1 Natural 5 Pending investigation	(Month, Day Year)	28b. Time of Injury	Work	es 2 No		ow injury occurred	
DIX	tal or Attend rs after death el Director: /	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined			eet, factory, office	2	28f. Location (Si City or Town	treet and Number or n, State)	Rural Route Number,
	he Hospital n 24 hours a he Funerel I pletely filled	edical	29a. Certifier Check only one) Certifying Ph	nysician: To the best of my knowniner: On the basis of examination and manner stated.	vledge, deatl ion and/or in	n occurred at the time vestigation, in my op	e, date and place, a inion, death occurre	and due to the coded at the time, d	ause(s) and manner late and place, and d	as stated. ue to the cause(s)
	To the I	W	29b. Signature and tile of certifier	m)		29c. License	300b]	9d. Date signed (Mo	onth, Day, Year)
_	100		30. Name and address of person who	completed cause of death (Item	23a) (Type,	Print) Hosp	itel b	~/ (2	In Br	Cen hium
	St Regist	ate rar	31. Date filed (Month, Day, Year) JAN 1 2 200	32. Registrar's Signat	ure Jose	w				

	1	For State Registrar				Depa		of He	alth a		ental Hy	_	36	00503
		Decedent's Name (First, Middle	e, Last)								2. Date of Dea	ath	Vone	3. Time of Death
Physicia: /Medica			El	isha	Albert	Pur	nell			Į	ANUAL	11 20	Year	18:27 M
Examine		4a. Facility Name (If not institution	, give street and	number)			4b. City, T	own, or L	ocation of	f Death			ty of Death	1
	8,	ST. AGNES	HOSP	TAC			136	267	non	2/5			Balti	more
Funeral		5. Social Security Number	6. Sex		Θ (In yrs. last i		If Under 1 Months	Year Days	If Under 2 Hours		8. Date of Birt (Month, Da)	h v. Year)	9. Birth	place (State or Foreign untry)
Director		218-16-5644	1 □ X M 2 □ I		82	Yrs.		,0	1.00.0			1923		Maryland
Pu *	-	Usual Residence of Decedent 10a. State 10b. County			10c. City, To	wn or Lo	cation							10d. Inside City Limits
aryla shov	_	Maryland	N/A		100. Oily, 10	, mil Ol EO	Cation	Dol	timore					1 X Yes 2 □ No
Ne M	ect		IN/A				100 7 0		uniore			40 000		
with 1	<u>ב</u>	10e. Street and Number 3932 Rokeby Road					10f. Zip 0	ode	2122			10g. Citizen of		
a 23	by Funeral Director		10 Mes F) a sadant	Ever in U.S.	10.10	Man Danada	at at bline			air. Van as Na	14 Pc	U.S.	A. ican Indian,
item Cert	5	 Marital Status Never Married 2 Marri 	Armed	Forces?		13. 4	Yes, specif	y Cuban,	, Mexican,	Puerto F	cify Yes or No- Rican, etc.)	BI	ack, White	
136 Ir, or	2	3 Widowed 4 XDivorced	If Yes	es 2 🗌 l , Give or Dates:	140	1	□Yes 2	No 🗶	Specify:			Spec	ify:	Black
21215-0036 d within 72 hours after death with the Maryland giene. er then "natural", or items 23s or 28e-1 show itte Madigal Examiner must be mylided at	e		t's Education		16	Sa. Deced	lent's Usuaf	Occupati	ion			16b. Kind of	Business/li	ndustry
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212 d with giene.	Completed	12	Coneg	je (1-4or 5	0+)			He	lper				Bak	ery
hd 2	a l	17. Father's Name (First, Middle,	Last)					1	18. Mother	r's Name	(First, Middle,	Maiden Suma	me)	
Vland	0 0	Flet	cher Purne	H							Fran	ices Purn	ell	
S PE E		19a. Informant's Name/Relations	hip (Type, Print)		11	9b. Mailin	g Address (Street an	d Number	r or Rura	Route Numbe	r, City or Town	n, State, Zi	ip Code)
e, Marita and 2 Health a em 27 le		Lloyd Purnell				39	32 Roke	by Ro	ad Bat	timore	, Maryland	21229		
of He		20a. Method of Disposition			20b. Place ceme	of Dispos	sition (Name	of er place)) T	D	ate	20c. Location	- City or T	Town, State
MOF Pages Tent of Int: If its	İ	1 🗷 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		om State			Zion Ce			0	1/10/06	Lans	downe,	Maryland
Baltimore, permit. Pages 1a Department of Het Important: If Item any injury or othe		21. Signature of Funeral Service	Licensee	2 1		-	. Name and			1	_			•
Department		- SURING	$f \in$	5%	20		Est	p Bro	thers F	unera	l Service, timore, Mo	P. A.		
		23a. Part1. Enter the disease, or shock, or heart failure. List	complications th	at caused	the death. D	o not ente	er the mode	of dying,	such as	cardiac or	r respiratory ar	rest,		Approximate interval Between
Physician		Immediate Cause (Final		~	1 .	1	1 1	1 1	eed					Onset and Death
/Medical		disease or condition resulting in death)			a consequence		nrian	Ο,						
Examiner				Pen	tic U	leer	- Dis	ea.	Se.					
	ē	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due Due	to (or as	a consequenc	e of):					-			
outed nd	Examiner	Cause (Disease or injury that initiated events) c.											
760, te be executed ysicien and te burial-transit	Ĭ	resulting in death) Last	Due	to (or as	a consequenc	e of):								
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Fecords, P.O. Box 68 The law requires that the attending phase been signed by the attending phase 2 should be delached for use as the	9	45 FEMALE												
Box eath cert attendin for use	by Physician/Med	fF FEMALE: 23b. Was decedent pregnant			of pregnancy 2 Fetal dea	ith 3	Ectopic pre	nancy				1	ate of deliv	
deal deal	200	in the past 12 months? 1 Yes 2 No	4 □ Pr		t time of death		Other (spec					N	lonth	Day Year
P.O.	Š	9 🗌 Unknown	3620	IKIOWII								1		
S, L	ò	Part II. Other significant condition	1			g in the ur	nderlying cal	ise given	in Part I.		23e. Did to	obacco use co	ntribute to	the cause of death?
Records,	9	, , ,	tens	_							101	res 2□No	3 🗌 Pro	bably 4 Onknown
e law r has be e 2 sh	ble	Advan	ced	Der	men-	tia.	•				24a. Was		. Were aut	opsy findings available omptetion of cause of
Vital Resident The Legal Contificate has irector, page 2	Completed											med? 2 No	death?	
	a	25. Was case referred to medica							26. Place	of Death	Check only o	/		
of Vita Physician: r this certifica	0	examiner? 1 ☐ Yes 2 No	Hospitaf: 1	☐ Inpatie	ent 2X ER/	Outpatien	t 3 DOA	Other	4 🗆 Nur	rsing Hor	ne 5 🗆 Resid	ience 6 🗆 O	ther (Speci	ify)
n on ng Pl	ä	27. Manner of Death ★★Natural 5 ☐ Pendir	/1	ate of Inju	ry 28b	. Time of	28	. Injury a Work?	at	2	8d. Describe h	now injury occu	irred	
Division or Attending after death. Director: After	ät	2 Accident investi	gation				М		es 2 🗆 N	No				
r Att	Ĕ	3 Suicide 6 Could 4 Homicide determ	ined 288. P	lace of Infuilding, et	ury - At home, c. (Specify)	farm, stre	eet, factory,	office		2	8f. Location (8 City or Tox	Street and Num vn, State)	ber or Rui	ral Route Number,
Division of Vita Volta Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical Certification:													
10sp 4 hou 1 hou 1 hou 1 hou	Ca	(Check only "2 Medical	ng Physician: To Examiner: On th	the best	of my knowled	lge, death and/or inv	occurred at	the time	, date and	d place, a	nd due to the	cause(s) and n	nanner as	stated, to the cause(s)
the I the I the I	Jed	one)	and r	nanner st	ated									
or with		29b. Signature and title of certifie	1-6	(/	/ N	10		License		~ 1	1	29d. Date sign		* '
		4 1100	4 17		- ///	~	L	000	53	31	4	Janu	ary	1,2006
2		30. Name and address of person Michelle 44	enggele	er, n	10	90			n A	lven	ue, Z	Baltim	ore,	1,2006 MO
State Registra		31. Date filed (Month, Day, Year)	2 2006	2. Redsi	ar's Signature	K for	berte	,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 2006 Rudolph Roles 6:15p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1910 Aisquith Street Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, 6-21-5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1∑M 2□ F 73 213-28-4008 Director Md. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Md. NA Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 1910 Aisquith Street 21218 2 should be filed within 72 hours after death and Mental Hygiene. Is marked other than "natural", or items 23 Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify þ Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Refinery Elementary/Secondary (0-12) College (1-4or 5+) Fork Lift Driver American Smelting & 8th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be mit. Pages 1 and 2 should be partment of Health and Ments portant: If Item 27 is marked y injury or other traumatic e 2 Henry Eloise Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley B. Roles Wife 1910 Aisquith Street, Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) permit. Page Department Important: If any injury or Md. Vet. Cem. 1-12-06 Crownsville, Md. 21. Signatury of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 & lady Would March F.H. East 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deat Immediate Cause (Final disease or condition resulting in death) Physician Metastan Adenocarcinomo 3 month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. ed by the attending physicien detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending after death.

Director: Af
d in by the fi 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 THomicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely ZU Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier January 10, 2006 00000 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Maryland 21287 600 North Wolfe Street 31. Date filed (Month, Day, Year) JAN 1 2 2006 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1- State Amend Item #1 Per Phy G851 1/27/106/tejif Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Stanley William 3. Time of Death Rodgers, Sr. Month Year **Physician** January 8, 2006 3:57 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 1622 Lynch Road Dundalk If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Min Days Hours 1 3M 2 ☐ F 217-26-4836 Director Jan. 3,1931 Ohio 75 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or itama 23a or 28e-1 show any injury or other traumatic avent, the Madical Exeminations. 10b. County 10c. City. Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2X No Director Maryland Baltimore Dundalk 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 United States 1622 Lynch Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2-☐ No ukn. If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√☐ No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Steel Industry 6 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Stanley O. Rodgers Emma Kiss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Mary C. Rodgers (Wife) 1622 Lynch Road Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ₩XBuriai 2 Cremation 3 Removal from State Oak Lawn Cemetery 1/11/2006 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Vietastatic Physician Nonsmall /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) nding physicien and use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Dav 4☐Pregnant at time of death 5 Other (specify) signed by the e 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 XYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificete 1 Yes 2 No Division of Vital To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this After this funeral of 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of De th 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A 2 Accident the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 01-09-2006 045530 -M.D MILLORDI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Philadelphia road Stute 208412147 9114 ASALYAM 32. Registrar's Signature State Registrar

			For State Registrar	State of M	farylan		artmer rtifica			nd Ment		jiene eg. No.	06	005	06
	Physici	an.	Decedent's Name (First, Middle, Last,							l N	ate of Dea Month	th Day	Year	3. Time o	
	/Medic		Patricia Speltz Ro				T				nuary	9,	2006		PM M
-70.	Examir	er	4a. Facility Name (If not institution, give Gilchrist Center f			re	4b. City		Location of Dowson	Death		4c. C	County of Deat Ltimore		
- (*) - (*)			Social Security Number 6. S			iast birthday) If Unde	r 1 Year	If Under 24	Hrs. A D	ate of Birth			hplace (State	or Foreign
	Funeral Director			M 25F	71	Yrs.	Months	Days	Hours	Min. 01	Month Day	Year) 1934	TN Co	untry)	or r or orgri
3			Usual Residence of Decedent				1		<u> </u>						
ylang	how H		10a. State 10b. County		10c. City	y, Town or L	ocation							10d. Inside (
N N	4	ctor	TN Shelby		Mem	phis								1 XYe	s 2 No
Ę	or 28	Oire	10e. Street and Number					Code					en of What Co		
5	23a	Funeral Director	621 S. McLean Blvd				38	104					ed Stat		
90	E L	nue!	11. Marital Status	 Was Decedent Armed Forces 	?	S. 13.	Was Dece If Yes, spe	dent of Hi cify Cuba	ispanic Origin In, Mexican, P	n? (Specify Y Puerto Rican	Yes or No- n, etc.)	14	 Race - Ame Black, White 		
36	ō	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Vivorced	1 ☐ Yes 27 If Yes, Give	•		1 🗆 Yes	2 X Vo	Specify:			5	Specify:Whi	te	
17275-0036 within 22 hours after death with the Maxland	a line	pg pg	15. Decedent's Edu	Year or Dates		16a Dec	edent's Usu	al Occup	ation		1		d of Business/		
. 2	age	ojet	(Specify only highest grad	e completed)		(Giv.		ork done o	durina most o	of working		Own		industry	
בו בו	ene L	Completed	Elementary/Secondary (0-12)	College (1-4o	f 5+) 4	Home	naker								
סַ	othe ont,	Be C	17. Father's Name (First, Middle, Last)						18. Mother's	s Name (Firs	st, Middle,	Maiden S	iumame)		
<u>ומי</u>	Aenta rkad tic e	To B	Matthew Speltz						Helen	Harri	is				
Maryland 21215-0036	and)		19a. Informant's Name/Relationship (T)				•						Town, State, 2	. ,	•••
Σ ;	n 27	13	Helen Roby Kennelly	/Daugnter			-		e Ct.	101			monium,		.093
altimore,	T te		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	Removal from Stat	9 0	lace of Disp emetery, cre	matory or	other plac	1		11		ation - City or		
	ment ant: lury	1	4 □ Donation 5 □ Other (Specify)		Che	esapea	-			200			sville,	Maryla	nd ————————————————————————————————————
Bal	Department of Hasilin and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show eny injury or other traumatic event, the Medical Examinar must be notified at once.		21. Signature of Funeral Service Licens	ee [[Moode	4	2. Name a Cremat 3717 G	nd Addres ion a reen	s of Facility ind Fund Pasture	eral Al es Driv	lterna ve Ba	tive:	s ore, Ma	ryland	
	hysician and burial-transit the burial-transit	dicai Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, the leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	as a consequence as a consequence	uence of:	Chr	CER						Interval Be Onset and	Death
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7	ned t	y Pi	Part II. Other significant conditions co	ntnbuting to death	but not res	ulting in the	underlying	cause giv	en in Part I.	2	23e. Did to	bacco us	e contribute to	the cause of	death?
ğ	an signature	ed								_ 1	1 Q Y	es 2	No 3□Pr	obably 4]Unknown
Reco	te has been signed age 2 should be de	Completed							. <u> </u>	-	24a. Was a autop perfor 1 □ Yes	sv	death?	utopsy finding completion of	s available cause of
E a	rtifica tor, p	O	25. Was case referred to medical				_		26. Place of	of Death (Che		7 -	10100		
Division of Vital Records, P.O.	within 24 hours after dealth within 24 hours after dealth within 24 hours after dealth within 25 hours after the prompletely filled in by the funeral director, page	ation: To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpa 28a. Date of In (Month, L	ijury	ER/Outpation 28b. Time Injury	of	28c. Injun Worl	y at	28d. i	5 ☐ Resid Describe h		Other (Specification)	cify) / + os	pice
Divis	within 24 hours after death. To the Funeral Director: After pompletely filled in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of building,	Injury - At he etc. <i>(Specif</i>	ome, farm, s	treet, facto	ry, office		28f. L	ocation (S City or Tow	itreet and n, State)	Number or Ru	ural Route Nu	mber,
200	24 hour	edicai (29a. Centifier 1 Centifying Phyone) 2 Medical Exam	sician. To the basis and manner	of examina	wledge, dea ition and/or	nvestigation	i at the un n, in my o	ne, date and p pinion, death	piace, and d occurred at	the time, o	date and p	and manner as place, and due	stateu. to the cause	(s)
F CF	withii To the	Me	29b. Signature and title of certifier	1 1				c. Licens				29d. Date	signed (Mont		
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	D'		30. Name and address of person who o	ompleted cause of	death (Iter	n 23a) (Type	Print)	in St	520s	to m	d 20	201	ĸ		
	St. Regist	ate rar	31. Date filed (Month, Day, Year) JAN 1 2 2	006 32. R égis	strar's Signa	ature.	park	3							

			For State Registrar	S	state o	f Maryla	nd / Depa	artmer <i>rtifica</i> :			ind M	lental Hy	giene Reg. Re	UU^{\dagger}	5 (0507
7 1983	Physicia		Decedent's Name (First, Middle JOHN F. SETTLE									2. Date of De JANUAR		^y 2006	Year)	3. Time of Death 12:50 AM
	/Medic Examin		4a. Facility Name (If not institution MILLENNIUM HEAL				TION	,	Town, or	Location o	f Death			County o		NDEL
* (4)	Funeral Director		5. Social Security Number 213-26-3259	6. Sex	2 🗆 F		s. last birthday) Yrs.	If Unde Months	r 1 Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da SEPT.	rth ay, Year) 23,1	929	9. Birthp Coun MARY	lace (State or Foreign try) LAND
	show	or	Usual Residence of Decedent 10a. State 10b. County MARYLAND ANNE A	RUNDE	et.		City, Town or L								1	0d. Inside City Limits 1 ☐ Yes 2 🛣 No
	r 28a-f	rect	10e. Street and Number						o Code				10g. Cit	tizen of W	hat Cour	itry?
	th with	alD	7976 NOLPARK CT	., AF	T. 1	01		21	.061				UNI	TED S	STATI	ES
9	72 hours after death with the Marylar "natural", or itsms 23e or 28a-f show refeal Examinar must be motified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🖫 Widowed 4 ☐ Divorced	ned .	Was Dece Armed For 1 ZYes If Yes, Giv Year or D	2 🗆 No	U.S. 13.	Was Dece If Yes, spe 1 Yes	crfy Cuba	ispanic Orig in, Mexican Specify:	in? (Spe Puerto	ecify Yes or No Rican, etc.)	0-	14. Race Black Specify:	, White,	etc.
00-01-3	s 1 and 2 should be filed within 72 hours after death with the Maryland If Health and Mental Hygiene. If the Alth and Mental Hygiene. Other traumatic svent, Its Mark as Examine must be motified at	ompleted t	15. Deceden (Specify only highe Elementary/Secondary (0-12)	t's Educat	ion		16a. Dece	edent's Usu e kind of w DO NOT o	ork done i	durina most	of works	ng	16b. K	and of Bus		
7	ygiene /giene er the	Con	7		College (MECH	ANIC					1	NUFAC		ING
ylailu	2 should be filed within and Mental Hygiene. Is marked other than aumatic svent, Ite M.	To Be	17. Father's Name (First, Middle, WILLIAM SETTLES							JEAN	RIG					
, Mai	and 2 sho saith and n 27 is m		19a. Informant's Name/Relations BARBARA SETTLES		•		7976	NOLPA	RK C	T., A	PT.					Code) ID 21061
<u>5</u>	Pages 1 nent of He int: If Iten iry or oth		20a. Method of Disposition 1 Apurial 2 ☐ Cremation	3 □Rem	oval from	State	. Place of Disp cemetery, cre	matory or	other plac			ll,		ocation - (
Dall	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is sny Injury or other tra		4 Donation 5 Other (S 21. Signature of Auneral Service			C		2. Name a	nd Addre	ss of Facility	y	2006 ERALLE	-Marian	20 79		E, MARYLAND
			23a. Part1. Enter the disease, or	complicat	tions that o	aused the de						-		KNIE	, LID	Approximate
	Physician /Medical Examiner		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a		(or as a cons	equence of):	C	An	yltor	ula					Interval Between Onset and Death
Ŕ		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b		(or as a cons										
,0070	icate be executed physicien and s the burial-transit	dlcal Ex	resulting in death) Last		Due to	(or as a cons	equence of):									
O. DOX O	The law requires that the death certifin te has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c.	1 Live t	tcome of pre- pirth 2 F nant at time o	etal death 3	□Ectopic p □ Other (s		,				23d. Date Mon		ery Day Year
cords, r	quires that n signed b uld be deta	by	Part II. Other significant condition	ons contri	buting to d	eath but not	resulting in the	underlying	cause giv	en in Part I.						ne cause of death?
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		BeC	25. Was case referred to medica examiner?		, ca			Da	Ser!		of Deat	h (Check only				2 110
> 5	Physician: rthis certific ral director,	မ	1 ☐ Yes 2 No	1			□ ER/Outpatie		OA Oth	er: 4 🔀 Nu		me 5□Res				y)
DIVISION	lending Peath. or: After I	Certification;	2 0,100100111	ng igation	28a. Date (Mon	of Injury th, Day Year) 28b. Time (Injury	of M	28c. Injur Wor 1 🗆	yat k? Yes 2 □ I		28d. Describe	how inju	iry occurre	ed	
2	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director After this certific completely filled in by the funeral director,	CertIf	4 Homicide determ	nined	build	ing, etc. (Spe						City or To	own, Stat	e)		ll Route Number,
	he Hosp n 24 hou hs Fune pletely fil	edical	29a. Certifier 1 🔼 Certifyi (Check only 2 Medical	ng Physic Examine	r: On the b	e best of my loasis of examiner stated.	knowledge, dea ination and/or i	ith occurre nvestigatio	d at the tir n, in my o	ne, date an pinion, dea	d place, th occuri	and due to the ed at the time	e cause(s e, date an	s) and mar id place, a	nner as s nd due to	tated. the cause(s)
	To the Company	Σ	29b. Signature and tale of certifie	ər				25	c. Licens	e number				_		Day, Year)
			100						DS	702	8		JA	NUARY	10,	2006
	2		30. Name and address of person ADIYA CHOPRA,				tem 23a) (Type ELY AVE		NAPOI	LIS, M	1ARYI	LAND 21	401			
	Sta Regist		31. Date filed (Month, Day, Year)	32. F	istrar's Si		Local	2	•						

			For State Registrar	State of	Marylar		artment of F		nd Mental Hy	giene	16	00508
7	3.5	7	Decedent's Name (First, Middle,	Last)					2. Date of De	ath		3. Time of Death
	Physicia /Medic		Anthony N. S	aglimbene					Jan. 5,	2006	Y <i>e</i> ar	4:00 A M
	Examin		4a. Facility Name (If not institution,	give street and numb	ber)		4b. City, Town, o	or Location of		4c. Count	y of Death	
			Joseph Richie H	ospice			Baltimo	re		r	ı/a	
	Funeral		5. Social Security Number	6. Sex 7 XIX M 2 ☐ F		last birthday)	If Under 1 Year Months Days		Hrs. 8. Date of Bir Min. (Month, Da	th y, Year)	9. Birthp	place (State or Foreign
1	Director		579-20-0812	ALA-IM ZLIF	79_	Yrs.			July 13	, 1926	Wash	ington DC
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation				1	10d. Inside City Limits
	daryl f eho	ō	MD /									X⊠Yes 2 No
	the t	rect	MD n/ 10e. Street and Number	a	ва.	ltimore	10f. Zip Code			10g. Citizen of	What Cour	ntry?
	deeth with the Maryland me 23a or 28a-f ehow rmust be notified at	Funeral Director	594 South Beech	field Ave.			21229				JSA	, .
	me 2	era	11. Marital Status	12. Was Deced	ent Ever in U	I.S. 13.		hispanic Origin	n? (Specify Yes or No Puerto Rican, etc.)		ce - Americ	
	or Ite	Fur	1 XNever Married 2 Marrie	Armed Ford	k/StNo						ick, White,	
03	ral', c	1 by	3 Widowed 4 Divorced	If Yes, Give Year or Dat	es:		1 □ Yes 🏋 No	Ѕреспу:	white	Specia	fy: WI	nite
21215-0036	72 h	Completed	15. Decedent's (Specify only highest	s Education grade completed)		(Give	ient's Usual Occup kind of work done	during most of	of working	16b. Kind of 8	Business/In	dustry
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S/A PE	d be f	Be	Agatino Saglimbe						enza	Maiden Sumai	тө)	
Maryland	hould id Me mark matic	5	19a. Informant's Name/Relationshi			19h Mailir	na Address (Street	1	or Rural Route Numb	er City or Town	State 7in	Codel
Z	trau		Charles J. Sagl		rother		-		ary, FL 32		, Olato, Zip	7 0000/
ှ စ်	s 1 ar		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name of		Date	20c. Location	- City or To	own, State
	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturat, or Iteme 23a or 28a-1 show any injury or other traumatic event, the Medical Examinat must be notified at an once.		1 ☐ Burial 全豆Cremation 4 ☐ Donation ,5 ☐ Other (Sp.		tate Ba	idon Pa	natory or other place Cremato irk	ry (d	n. 8, 06	Balti	more	City
S ≣	mit. Partmoortan		21. Signature of uneral Service L						Loudon Pa			
	Depa Depa Impo any is		+ KIM >	Schla	na	C 36	20 Wilke	ns Ave	. Baltimor	e, MD 2	1229	
	A		23a. Part 1 Enter the disease, or o shock, or heart failure. List of	complications that car	used the deat	th. Do not ent	er the mode of dyir	ng, such as ca	ardiac or respiratory a	rrest,	- /	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Li	WI	non	II of	1111	1/1/1	h mi	1/4	Onset and Death
	/Medical		resulting in death)	Due to (o	ras a consec	quence of):	a b	14/1	9 4/11	71111/2		1///
Je Je	Examiner		Sequentially list conditions	b								P
nbene	שָּׁי עַ	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	r as a consec	quence of):						
- A	and -trans	Cam	that initiated events resulting in death) Last	C	r as a consec							
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200	> 0 0	Completed		/					24a. Was	an 24b.	Were auto	ppsy findings available
R.	The tay ate hes bage 2	E								osy rmed? 2 2 No	prior to co death? 1 \(\) Yes	opsy findings available impletion of cause of
T I		Bec	25. Was case referred u medical					26. Place of	1 □ Yes of Death Check only o		1000	2010
÷ >	Physicien: this certific ral director,		examiner? 1 ☐ Yes 2 D No	Hospital: 1 ☐ In	patient 2	ER/Outpatier	nt 3 DOA Oth	ner: 4 ☐ Nurs	ing Home 5 ☐ Resi	dence 6 20t	her (Specif	HD+DIMI.
0	Jing Pl J. After th funeral	ii.	27. Mann of Death 1 L atural 5 □ Pending	28a. Date of (Month	Injury , Day Year)	28b. Time o Injury	28c. Injur Wor	ry at rk?	28d. Describe	now injury occu	rred	Lashur
<u>s</u> .	Attending r death. ector: After by the fune	cati	2 Accident investig	ation				Yes 2 □ No	0			/
Division of	or At fter d Strect in by	Certification: To	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine	28e. Place of building	of Injury - At h g, etc. (Speci	iome, farm, sti <i>fy)</i>	eet, factory, office		28f. Location (City or To	Street and Num vn. State)	ber or Rura	al Route Number,
ω	pltel ours a eral E		29a. Certifier 1 Pertifying	Objection Table 1					1			
	Hos 24 ho Fun stely	Medical	29a. Certifier 1 Pertifying (Check only one) 2 Medical E	xaminer: On the bas and manne	sis of examina	owledge, deat ation and/or in	n occurred at the tir vestigation, in my o	me, date and opinion, death	place, and due to the occurred at the time,	cause(s) and m date and place,	anner as s , and due to	tated. o the cause(s)
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Me	29b. Signature and title of certifier	and maine	. stated.		29c. Licens	se number		29d. D. igne	ed (Month.	Day, Year)
	⊢s⊢ŏ		12/11/2/	MILLEDA	M		DI	あわり	7	111	1/4	DIAL
	1	2	30. Nat a ind address of person a	no pleted cause	of death (Ites	m.23a) (7vna	Print	1010	2/ -	UUM	1	1-000
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	✓ Sta	ite	31. Date filed (Mon h, Day, Ye	32. Re	gistrar's Signi	ature	i will	1 161	- 411	11/11/11	100	-7 0
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			For State Registrar	State of	Marylan		artment of H tificate of L		nd Mental H	ygiene Reg: No.	06	00509
	DI		1. Decedent's Name (First, Middle, Las	t)					2. Date of I		Year	3. Time of Death
	Physicia /Medic		Florence Helen	Sommer					Januar			11:00 AM
	Examin		4a. Facility Name (If not institution, give		ber)		4b. City, Town, or	Location of	Death		ounty of Death	
			Riverview Care Cen			la a blata ta a	Essex If Under 1 Year	If Under 2	14 Hers 0 D		altimor	
	Funeral		5. Social Security Number 6. Se 11	x ⊐M2√E√F	. Age (In yrs. I 95	ast birtnday) Yrs.	Months Days	Hours	Min. (Month, I	Day, Year)	Cou	
	Director	-	Usual Residence of Decedent		93				Dec. 3	3, 1910	O Ohio	
	yland		10a. State 10b. County			, Town or Lo						10d. Inside City Limits
	Mar-f st	tor	Maryland Baltimor	e	Pá	arkvil.	Le					1 ☐ Yes 2⁄2 No
	permil. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examinat notal by rediffied at once.	Funeral Director	10e. Street and Number 7717 Daniels Avenu	ıe			10f. Zip Code 21 234			10g. Citize	en of What Cou	ntry?
	deatl	ner	11, Marital Status	12. Was Deced	lent Ever in U.	S. 13.	Was Decedent of H	ispanic Orig	in? (Specify Yes or I Puerto Rican, etc.)	No- 14	I. Race - Ameri Black, White,	
9	or Ite	교	1 Never Married 2 Married	1 Tes 2 If Yes, Give Year or Da	No.		1 ☐ Yes XXXNo	Specify:	, 1 40,10 1 110411, 010.7		Specify:	
	ural',	d by	3 ∰Widowed 4 □ Divorced		tes:						Wnı	
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7	withi ene. then	E C	Elementary/Secondary (0-12)	College (1-	4or 5+)		maker	-7		Own	n Home	
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Maryland 21215-0036	should be ind Mental marked o	To B	Rocco Valentine					Ange.	line Passe	errell	i	
lan	2 sho and l		19a. Informant's Name/Relationship (7				_		r or Rural Route Nun	-		
	1 and Health em 27 ther tr		Ronald Sommer (Sor	1)	20b B		Bauernsc sition (Name of	rimiat	Drive, Es	-	Marylaii ation - City or T	
ğ	Pages nent of hant of hant: If ite		20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐			emetery, crei	natory or other place Cemetery		an.13,200			
Baltimore,	il. Pa intmer intent injury		 4 □ Donation 5 □ Other (Specify 21. Signeture o Funeral Service kipen 		Pal		_		-			
Ba	permil. Page Department of Importent: If any injury or		John W. Bu	Kous	ke		1407 OIG	Laste		, Esse	ome, P. x, Mary	A. land 21221
			23a. Part1. Enter the disease, or composition, or heart failure. List only	olications that ca	used the deat	h. Do not en	ter the mode of dyin					Approximate Interval Between Onset and Death
	Pnysician /Medical	i V	Immediate Cause (Final disease or condition resulting in death)	a	LDO	ham	C 6	i a	iamyoj	59000	9	un-Knun.
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8760,	icate be executed physiclan and s the burial-transit	Physician/Medical		. d								
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Вох	aath c attend for us	lan	23b. Was decedent pregnant in the past 12 months?	1 Live bi	nth 2 ☐ Feta Intat time of d	ldeath 3[Ectopic pregnancy Other (specify)	/		23	3d. Date of deliv Month	Pery Day Year
P.O.	that the de led by the a detached t	yslo	1 □ Yes 2 □ No 9 □ Unknown	9☐ Unkno		eatii 5t				-		
	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by Pf	Part II. Other significant conditions of	ontributing to de	ath but not res	ulting in the u	inderlying cause giv	en in Part I.	23e. Di	d tobacco us	e contribute to	the cause of death?
rds	w requires that s been signed k should be det	ed b	renor -	faulu	Q,	150	ami o	1	1[]Yes 2□	INo 3 ₽ro	bably 4 Unknown
000	e law re has bee	plet	Severa	L C	OPI)			24a. W	as an topsy	24b. Were aut	opsy findings available ompletion of cause of
ž		Completed							pe 1 \(\text{Yes}	rformed?	death?	2 46
ita	ysiclan: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?						of Death (Check on	y one)		
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isic	Attending Physiclan: r death. ector: After this certifics by the funeral director.	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b		of Injuny - At h	ome farm st	M 1 1	Yes 2 □ h		(Street and	Number or Rui	ral Route Number,
Division of Vital Records,	lor A after Direction by	ertification;	4 ☐ Homicide determined	buildin	g, etc. (Specil	(y)	reet, lactory, office			Town, State)		
-	To the Hospitel or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	calC							d place, and due to the time			
	the H the F the F nplete	Aedical	one)	and mann		vir and/or if			Journal at the till			
	Son Con	Σ	29b. Signature and title of certifier	D			29c. Licens	3 A	754	290. Date	signed (Month,	2-00G
•	10		20 Name and address of	completed	of death (It-	n 93c\ /T =	Print)		, – ,		r 2	2006
	5		30. Name and address of person who	WASE	EM.	70	q. BAS	STE	RN BL	VD.	M-D	-2/22/
	Sta	ite	31. Date filed (Month, Day, Year) JAN 1 2 20	06	gistrar's Signa	a A						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Garland January 4, 2006 6:45 AMM George Smith /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Virginia **Funeral** 1 ☐ M 257 F 225-12-6492 85 Yrs 1920 Director Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Worle ir then "naturel", or iteme 23s or 28s-f ehov 1 XYes 2 No Director Maryland Howard Dayton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14036 Big Branch Drive 21036 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 to Yes 2 □ No II Yes, Give Year or Dates: 1964 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Tech Sgt. U.S.A.F. permit. Pages 1 and 2 should be filed w Depertment of Heelth and Mental Hygien Importent: if Item 27 I e marked other th eny fijury or other treumatic event, tra ence. 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Smith Mariam Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Smith (Son) 14036 Big Branch Dr., Dayton, OH 21036 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1/7/06 4 ☐ Donation 5 ☐ Other (Specify) Princess Anne Mem. Park Virginia Beach, VA 22 Name and Address of Facility Hollomon-Brown Funeral Home & Crematory 8464 Tidewater Dr., Norfolk, VA 23518 21. Signature of Funeral Service Licensee ennes 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pneumonia Physician /Medical Due to (or as a consequence of). Examiner Severe Dehydration Sequentially list conditions, if any, leading to influed accase. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physicien and the burial-transit Hypernatremia Due to (or as a consequence of): Box 68760. Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ğ Month 4 Pregnant at time of death 5 Other (specify) signed by the e P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by Severe Dementia cate hes been signification category. 24 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24a. Was an autopsy performed?
1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending hours efter death. 1 Tyes 2 No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

To the Hospital or within 24 hours of To the Funerel D crmpletely

Medical

hame ha

D60829

January 5, 2006

30. Name and address of person who completed cause of death (I-m 23a) (Type, Print) 1500 Forest Glen Rd., Silver Spring, MD 20910

2006

Padmalath Moole, M.D. 31. Date filed (Month, Day, Year)

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** JANUARY **JACOB** 2006 4:45 A SALTZMAN 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BRIGHTON GARDENS OF PIKESVILLE PIKESVILLE BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) FEB.1,1909 Birthplace (State or Foreign Country) **Funeral** 1**∑** M 2□ F 220-05-5269 96 Director MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any Injury or other traumait: event, Ira Macdical Examiner must be matified at once. 1 Tes 2 No Directo BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 1840 REISTERSTOWN ROAD USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No WHITE Specify: Specify Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PHYSICAL THERAPIST ALLIED HEALTH 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be **ISAAC** SALTZMAN DORA CHOZEN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 HURLINGHAM COURT - BALTIMORE, MD 21208 JANICE DANSICKER / NIECE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HEBREW YOUNG MEN CEM. 1/11/2006 WOODLAWN, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) use as the burial-P.O. Box 68760, the ettending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) cate hes been signed by the case has been signed by the case 2 should be detached. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 Yes 2 Liber 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? After this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 (2 No funeral director. 25. Was case referred to medical 26. Place of Death Check only one examiner? Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ ₩6 Certification; To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: Al
completely filled in by the fu м 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the hest of my knowledge statch occurred at the time, date and place and due to the causelst and manner as stated cai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) å 29b. Signature and title of cept 29c. License number 29d. Date signed (Month, Day, Year) 016941 cause of death (Item 23a) (Type, Print) 1/15, md 2/117 O a Inon 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** G. TRIIPP 8.25 PM GARRISON January 8 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Mac. curity Number 8. Date of Birth NOV.12, 1913 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 92 Yrs. 212-40-5761 MD Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits or 28e-f ehov the Medical Examiner must be notified at 1 ¥Yes 2 □ No Funerai Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? or items 23a 7111 PARK HEIGHTS AVENUE #509 21215 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. WWII 1 XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married WHITE 1 Yes 2 No Specify: Specify δ 3 Widowed 4 Divorced ARMY "naturel". Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: if item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) DENTIST DENTAL traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be NATHAN TRUPP REBECCA SARON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHANNA ZENTZ / NIECE 11525 FALLS ROAD - LUTHERVILLE, MD 21093 other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State in ury or permit Page Department of Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) BALTIMORE HEBREW CEM. 01/11/2006 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Prvice License 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease shock, or heart failure. I Immediate Cause (Finat disease or condition resulting in death) Physician (02 3 days /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner use as the burial-transit or Attending Phyalcian: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death signed by the a 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? 1 Yes 2 NO funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 3 DOA 27. Manner of Death 1 Naturat 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After 5 Pending after death.

I Director: Alt d in by the fun 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide Hospital 24 hours a Cartifying Physician: To the hist of my knowledge. Just his uncurad at the time, date and black, and due to the causa(s) and his man as stated 29a Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the 29c. License number 29b. Signature and title of certifie DOOG 3322 January 8, 2006

Hospital of Baltimore, 240/W Belveder Ave, Coltimore, MD 21215

strars Signature 3. Name and add person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

JAN12

2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend iseme of Marylahos 52 partment of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Melvin Bernice Vogt Jan 2000 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death BALTI MORE
If Under 1 Year | Hunder 24 Hrs. AGNES TAI n/a 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Y1921 Birthplace (State or Foreign Country) Months Days Hours XXXM 2DF Yrs. 219-05-1542 85 Jan. 26, 1922 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1-Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2624 Lehman St. 21223 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Amed Forces?

1 ☐ Yes 2 ☑ No

If Yes, Give

Year or Dates: 1 Never Married 2 Married 1 Yes 2√2 No Specify: white Specify: white 3 Vidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Improvements Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Bernice Vogt Katherine Pfeifer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diana Shipley - Daughter 2624 Lehman St. Baltimore, MD 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 St Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery Jan. 14, 06 Baltimore City ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Ansee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, MD 21229 23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA 2 WEEKS disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ICILE 1 Yes 2 No 3 Probably 4 Wunknown COLITI 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? EMENTIA 1 ☐ Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending 1 Yes 2 No investigation 6 ☐ Could not be 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29c. License number

(000V100)

29d. Date signed (Month, Day, Year)

Jan 10,2006

BATIMORE MO 21229

/Medical **Examiner** The law requires that the death certificate be executed of Vital Hospital or Attending Physicien: Division within 24 hours af To the Funerel D completely filled in

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Item 27 is marked other then "neturel", or Items 23a or 28a-f shov other treumatic event, the Medical Examinar must be rediffed at

and Mental Hygiene.

t of Health

Physician

the burial-transit

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page 2 should

director

filled in by

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after death Director:

ö permit. Page Department of Importent: If any injury or once. Completed by Funeral Director

Be

Physician/Medical Examiner

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Be Completed

Certification: To

Medical

State Registrar

31. Date filed (Month, Day, Year) DHMH 17 Rev 1/2001

TIENNE

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NIGOU MGNA

ORIGINAL

			_ State	State of Marylan		ment of l		Mental Hy	1	UUD =	00514
			Registrar 1. Decedent's Name (First, Middle, Last)		Ochin	icate or	Dealii	2. Date of De	Reg. No.		3. Time of Death
	Physicia	an	BRENDA D. WILLIAMS					Month	Day	Year 10 30 4	9:48P M
	/Medic		4a. Facility Name (If not institution, give str	root and number	4	h City Town	or Location of Death	DAU	-	County of Death	1.70
	Examin Funeral	er	Franklin Square 5. Social Security Number 9 6. Sex	Hospital M. Age (In yrs. 35	last birthday)	Under 1 Year	sedale	8. Date of Bi	irth ay, Year)	Baltu 9. Birthe Coul	* /
	Director		Usual Residence of Decedent	33				AUG. 26	19/1	0 MARY	LAND
	death with the Maryland Ime 23a or 28e-f ehow		10a. State 10b. County	10c. Cit	y, Town or Locat	ion				1	0d. Inside City Limits
	with the Maryland a or 28e-f ehow be retified at	ğ	MARYLAND ANNE ARUNI	OFT GLEN	N BURNIE						1 ☐ Yes 2 No
	28e	Director	10e. Street and Number	DEL CHE	DOMNIE	10f. Zip Code			10g. Citi	zen of What Cour	ntry?
	3a or		700 DELMAR AVE			210	261		IINTT	ED STATE	'S
	iteme 2	Funeral	11. Marital Status	2. Was Decedent Ever in U	.S. 13. Wa	s Decedent of	Hispanic Origin? (SI	pecify Yes or N		14. Race - Americ	can Indian,
Z	or ite	Ē	1 X Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☒ No			ban, Mexican, Puerti	o Rican, etc.)	į	Black, White,	etc.
3 8	ol', o	þ	3 Widowed 4 Divorced	If Yes, Give ** Year or Dates:	1 _	Yes 2∭ No	o Specify:		į	Specify: WHI	TE
5/215-0036	within 72 hours after ene. than "naturel", or ite he Madical Examire	Completed	15. Decedent's Educa (Specify only highest grade		16a. Deceden	t's Usual Occu	upation	kina	16b. Ki	nd of Business/In	dustry
21	thin thin	ם	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO	NOT use retire	e during most of wor. ed)	9			
	filed with Hygiene other tha	Co	12		TELEM	ARKETIN				LES	
Du	be file	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle	e, Maiden	Sumame)	
$\sqrt{\frac{x}{a}}$	should be and Mental ie marked o eumatic eve	9	EDWARD LEE WILLIAM	MS			MARY AN	IN BEVAN	I		
$\mathbb{M} \lesssim M$	s 1 and 2 should be filed within 72 hours after death v Health and Mental Hygiene. If Mazi e marked other than "hatural", or iteme 23a other treumatic event, the Madical Exantiner must		19a. Informant's Name/Relationship (Type	e, Print)	19b. Mailing	Address (Stree	et and Number or Ru	ral Route Numb	ber, City o	r Town, State, Zip	Code)
≥ ≥	and ealth m 27		MARY ANN WILLIAMS /			LMAR AV	VE. GLEN	BURNIE,			
); \\ ì ∆ altimore	permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other tre		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Re		Place of Dispositi cemetery, cremat	on (Name of ory or other pla	JAN	Date IUARY	20c. Lo	ecation - City or To	own, State
, Ē	Pag ment ant: ury c		4 Donation 5 Other (Specify)		WNSVILLI	E MD VE	ET. CEM. 1	3,2006	CRO	WNSVILLE	E. MD
alt	apart aport ny inj		21. Sign Jure of Funeral Service Licenses	0	22. N K T	ame and Addr	ress of Facility RUDDICK FU	NERAT. E	IOME	РΔ	
$\mathcal{Q}_{\mathbf{n}}$	2011		THE THE		42	CRAIN	HWY. S.E	GLEN	BUR	NIE, MD	21061
			23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one	ations that caused the dear cause on each line.	h. Do not enter	he mode of dy	ring, such as cardiac	or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Herata	renal	Sun	dromi	0			Onset and Death
	/Medical		resulting in death)	Due to (or as a consec	uence of):	0,	1	,			
4	Examiner		Sequentially list conditions. b.	Hepatic	- Fn(epho	a lopat	hy			
	ס ≒	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to for as a consec	juence of):	1	•	J			
V	be executed icien and burial-transit	Examiner	that initiated events c. resulting in death) Last	Cirrnog	515						
8760,	sien s		resulting in deathy East	Due to (or as a consec	(uence of):						
876	cate be ex physicien the buria	dlcai	d.								
9		Me	IF FEMALE:								
30)	Physician: The law requires that the death certificate this certificate hes been signed by the ettending rail director, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	 c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 	al death 3 □Ed	topic pregnan	су		1	23d. Date of deliver Month	ery Day Year
0.	the e	/slc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of o	death 5□C	ther (specify)					Ju, 130
Р.	d by	F.	Part II. Other significant conditions cont	sibution to death but not see	ulting in the west			220 Did	tohonen	on nontribute to t	he cause of death?
<u>v</u> î	signe d be d	b	Part II. Other significant conditions cont	nouting to death out not res	sulting in the unde	riying cause g	given in Parti.			/	he cause of death?
0.0	w requir been si should	ted							Yes 2	 ¥140 2∏±10r	Dably 4 DOTKHOWN
ec	e law hes b	Completed						24a. Wa auto	opsy	prior to co	ppsy findings available impletion of cause of
<u> </u>	ding Physician: The n	ပ္ပ						perf 1 ☐ Yes	fòrmed? 2 Xi No	death?	2 🗆 No
/ita	ician: Th certificete rector. pag	Be	25. Was case referred to medical examiner?	,			26. Place of Dea	th (Check only	one		
_	shysi this c	မ	T Yes 2000		ER/Outpatient	3 DOA				6 □Other (Specif	ý)
Ē	ding P. After (ë	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inj.		28d. Describe	how injur	y occurred	
S.	Attending r death. ector: After 5y the fune	catl	2 Accident investigation 3 Suicide 6 Could not be				☐ Yes 2 ☐ No				
Division of Vital Records, P.O. Box	fter direct	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	iome, farm, stree fy)	, factory, office	8	28f. Location City or To	(Street an own, State	id Number or Rura i)	al Route Number,
	To the Hospitei or Attend within 24 hours after death To the Funeral Director: completely filled in by the										
	Hosp 4 hor Fune	ca	(Check only 2 Medical Examin	ician: To the best of my kn er: On the basis of examin	owledge, death o ation and/or inves	ccurred at the tigation, in my	time, date and place opinion, death occu	, and due to the rred at the time	e cause(s) , date and	and manner as s place, and due to	tated. o the cause(s)
	thin 2	Medical	29b. Signature and title of cettifier	and manner stated.			nse number			te signed (Month,	
	Z Z Z 8		MAN		2		_				
			THOMEST	M	.1)-	1/4	e50000		1/10	106	
	10		30. Name and address of person who con	inpleted cause of death (Ite	m 23a) (Type, Pr	nt)	A LOURS DAS	10 A	iL		10.21237
	U		31. Date filed (Month, Day, Year)	32. Remistrar's Sign	TIQNY)	111 3	vaic PM	UC, IOC	21/1)	nore, "	10.0125/
	Sta Regist			ing Se a	14 1	- 40		•			

			for State Registrar	State of Marylan			of Health and of Death	Re	2 U U U	00515
*	Physicia		Decedent's Name (First, Middle, Last) VERNON	G.		WATKI	NS , SR.	2. Date of Death Month	Day Year 8 2006	3. Time of Death 2252 M
	/Medic	-	4a. Facility Name (If not institution, give s	treet and number)		4b. City, To	wn, or Location of Dea	th	4c. County of Dear	h
*		£5.	4320 Clareway Ar	ot. 7 C			Baltimore	e	NA	
1	Funeral Director		5. Social Security Number 6. Sex 113	7. Age (In yrs.	last birthday) Yrs.	If Under 1 \	ear If Under 24 Hrs ays Hours Min		Year) 9. Birt	hplace (State or Foreign buntry) Md.
35			Usuaf Residence of Decedent	7.1						
	yłanc how		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. fnside City Limits
	e-1-e	cto	Md. Na		Balt	imore				1X1Yes 2 □ No
	or 28	Director	10e. Street and Number			10f. Zip Co	ede	10	g. Citizen of What Co	•
	23a			ot. 7_C		21	.213		USA	1
	er dee	Funerai		Was Decedent Ever in U Armed Forces?	.S. 13. \	Was Decedent Yes, specify	t of Hispanic Origin? (Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whit	
36	filed within 72 hours after deeth with the Maryland Hygiene. ther then "naturel", or items 23e or 28e-f ehow ther then "naturel", or items 23e or 28e-f ehow ont, the Mydical Examinar must be notified at	by Fu	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 【 X No If Yes, Give Year or Dates:		1 □ Yes 2 💆	No Specify:		Specify: B	Lack
21215-0036	hour	edr	15. Decedent's Educ		16a, Dece	dent's Usual C	ecupation	1	6b. Kind of Business	Industry
15	n "na	Completed	(Specify only highest grade	completed)	(Give	kind of work of DO NOT use	lone during most of we	orking		,
212	r the	E O	Elementary/Secondary (0-12)	College (1-4or 5+)		Mainte	enance		Federal	Reserve
ᅙ	othe	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle, N	laiden Sumame)	
Maryjand	ould by Menta	ToE	Samuel		Watkins		Rita		Connor	
N N	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mentat Hygiene. Importent: if item 27 is marked other than "naturel", or items 23a or 28e-f show any injury or other traumatic event, the Mudical Examinar must be notified at ance.		19a. Informant's Name/Relationship (Type Pyllis Watkins-Be				treet and Number or F hill Road,			1218
altimore,	s 1 a of Hea item othe		20a. Method of Disposition		Place of Dispo	sition (Name	of r place)	Date 2	Oc. Location - City or	Town, State
Ĕ	Page nent c ant: if		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	King Me	·	_	-14-06	Randallst	own, Md.
a	rmit. poartn porte y inju		21. Signature of Funeral Service License	90	22	2. Name and	Address of Facility	Balt	imore, Md	. 21202
<u> </u>	89 8 8		Glades	Wane	ノ	March	F.H. East	1101	E. North	Ave.
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ie cause on each line.						Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Atheev	Sclee	otic C	aldio va	scular DI	sease	Jean
	/Medical Examiner		lesulting in death)	Due to (or as a conseq	uence of):					0
	nd.	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uence of):					
V	cuted nd ransit	Examiner	that initiated events							
0	e exec	EX	resulting in death) Last	Due to (or as a conseq	uence of):					
8760,	icate be executed physicien and s the burial-transit	dicai		l						
9	ertific ding p	Med	IF FEMALE:	2- Huan automa of acom	£2					
Вох	ettend for us	ian	in the past 12 months?	3c. If yes, outcome of pregna 1□Live birth 2□Feta 4□Pregnant at time of d	Ideath 3[Ectopic preg			23d. Date of de Month	livery Day Year
o.	that the death certified by the ettending detached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	eatti 5	1 Other (spec	(y)		ą.	
a	The law requires that the death certifi ate hes been signed by the ettending I page 2 should be detached for use as	y Ph	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying cau	se given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ds	uires n sign	d by	Sei rue disc	rdea				1 □ Ye	s 2 No 3 P	obably 4 Unknown
<u>o</u>	w require s been si should I	jete						24a. Was ar	24b. Were a	utopsy findings available
Vital Records,	The lav te hes age 2	Completed						autopsy		completion of cause of
ta		Be C	25. Was case referred to medical	2000			26, Place of De	1 ☐ Yes 2 eath <i>Check only one</i>	/	2,20,140
>	Physician: r this certific ral director,	To E	examiner? 1 Tes 2 No	lospital: 1 Inpatient 2 I	ER/Outpatier	nt 3 DOA	Other: 4 Nursing	Home 5 Reside	nce 6 Other (Spe	city)
n of	ding Ph h. After thi funeral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c	Injury at Work?	28d. Describe ho	w injury occurred	
<u>Ö</u>	Attending ar death. ector: After by the fune	atic	2 ☐ Accident investigation			М	1 Yes 2 No			
Division	or Att after de Direct in by t	Certification:	3 Suicide 6 Could not be determined	28e. Pface of fnjury - At h building, etc. (Special		reet, factory, c	ffice	28f. Location (Sti City or Town	eet and Number or R , State)	ural Route Number,
_	To the Hospitel or Attentwithin 24 hours after death To the Funerel Director: completely filled in by the		29a. Certifier 1X Certifying Phys	sicien: To the best of my know	wledge, deat	h occurred at	the time, date and place	ce, and due to the ca	use(s) and manner a	s stated.
	the Hin 24 the Fu	ledical	one)	ner: On the basis of examina and manner stated.	ilion and/or in					
	To T Com	Σ	29b. Signature and title of certifier	01.1.			icense number	29	d. Date signed (Mon.	h, Day, Year)
•	Λ		P (XUX	muns			32158		1/11/06	
	3		30. Name and address of pe sop who co	mpleted cause of death (Iter	n 23a) (Type,	Print)	4.00 1.	1107 0	Art	MD 21201
	05 F 10		31. Date filed (Month, Day Year)	y MD 8211	ature tu	Jaw S	seet, ste	2 40 1 18	alumole	m 4201
1	Sta Regist		JAN 1 2 Z006	32. Registrar's Sign.	Lase					

State of Maryland / Department of Health and Mental Hygiene () () 6

00516

							Ce	rtificat	te of	Death	7		Reg. No.		
	D		1. Decedent's Nam	e (First, Middi	le, Last)							2. Date of D			3. Time of Death
	Physic /Medi		Constance		C.		Woods					Month January	Day / 3,	Year 2006	8:00 am
1	Exami		4a. Facility Name (i	If not institution		umber)				4b. City, To	own, or Le	ocation of Dea		ty of Death	0:00 aiii
4	LAGITIII	ici	Greater Lau	rel Hea	lth Rehabil	itation	Center			Laure			101.000	ce Geor	2000
			5. Social Security N		6. Sex		yrs. last birthday	If Under	r 1 Year			P. Date of B	1		
	Funeral Director		233-54-793		1□M 2K F	93	-	Months			Min.	(Month, D	irth ay, Year) er 12, 19	9. Birthi	plece (State or Foreign htry) 'Ginia
	Director	ļ	Usual Residence of			J.						Decembe	er 12, 19	IZ VII	ginia
	end *		10a. State	10b. County		10c	. City, Town or L	ocation						1.	Od. Inside City Limits
	Aary Sp. Sp.	5	Manuland	Deine	C		_								1⊠ Yes 2 □ No
	28. The 1	Director	Maryland 10e. Street and Nu	1	Georges		Laurel	T							
:	o within 72 hours efter death with the Marylend jene. Than "natural", or thems 23a or 28e-f show the Medical Examinet must be notified at	큡	ice. Street and Nui	mber				10f. Zip	Code				10g. Citizen o	f What Cou	ntry?
;	ath 23	<u>a</u>	15748 Mille	prook Lar	ne			207						States	America
	e E	Funeral	11. Marital Status		12. Was De Armed I	cedent Ever i Forces?	n U,S. 13.	Was Dece	dent of I	Hispanic Or	rigin? (Sp	ecify Yes or N Rican, etc.)	o- 14. R	ace - Americ	
2	o effe		1 Never Marr		If Yes C	2X∏ No		1 ☐ Yes							
Š	ours	l by	3 Widowed	4 Divorced	Year or			103	-X''	opecity.	•		Spec	^{any:} B1a	ck
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72	·	5	7			(,	House	wife					Own	Ноте	
פַ	be tiled ntal Hygi od other event, t	Be (17. Father's Name	(First, Middle,	Last)					18. Moth	er's Nami	e (First, Middle	, Maiden Sum		
<u>a</u>	ould be Mental Marked o	To E	William Har	grow						Minnie	e Agee				
Maryland	3393	-	19a. Informant's Na	ame/Relations	hip (Type, Print)		19h Maili	na Address	S (Street				per, City or Tow	n State Zir	Code
		1	Frances Bro												0006)
o .	other		20a. Method of Disa		gircei	20	b. Place of Disp			Lane L	Laurei				
Ď.	0 0 = =				3 □Removal from		cem <i>etery</i> , cre	matory or o	ther pla	ce)	1	Date	20c. Location	1 - City or 10	wn, State
<u>.</u>	ortmer ortant: njury		4 Donation			1	√ational (remato	ry		1	/6/2006	Falls	Church	
Baltimore,	permit. Pag Depertment Important: I any injury o		21. Signature of Fu	Service	Licensee		£1	2. Name an eck Fu	d Addre	ss of Facili	ity				
ш	207 2 2 2	8	> X	Man	S 1/1.	Ma					Road	Laurel	Maryland	20707	
		\vdash	23a. Part1. Enter ti	he disease, or	complications that	caused the d									Approximate
	husisian	8 16	shock, or hea	rt failure. List	only one cause on	each line.			o o o,		our diad (or respiratory t	111031,	1	Interval Between Onset and Death
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Ē	Examiner		disease or condition resulting in death)		a. (ayo	110-1	<u><es< u=""></es<></u>	5/7/	ruto	774	da	ilme		
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ox 68760,	in centificate be executed ending physician and ruse as the burial-transit	an/Medical	that initiated events resulting in death) I	,	C. 1	Due to	(or as a consec	uence of):							
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S	dea ctor y the	ig	3 Suicide	6 ☐ Could r	not be	e of Injury - A	t home, farm, str					28f Location (Street and Mur	bor or Pum	/ Route Number,
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Tolore Leader	to the most and are the death into the within 24 hours efter death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	29a. Certifier (Check only one)	2 Madical	g Physician: To th Examinar: On the t	pasis of exam	knowledge, deatl ination end/or in	occurred a estigation,	at the tin in my o	ne, date an pinion, dea	d place, a th occurre	and due to the ed at the time.	cause(s) and n date and place	nanner as st , and due to	ated. the cause(s)
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چ	should and Men marke	P	19a. Informant's Name/Relationship	(Type, Print)	19	b. Mailing A	Address (Street		ral Route Number		State. Zip	Code)
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	(h)		30. Name and address of person wh	completed cause of d	eath (Item 23a)	(Type, Prin	TO CC	LO NI	D Tet	ferr	er	
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DHMH 16 Rev 6/95

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Baltimore, Maryland 21215-0036

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			1 = For State Registrar	State of Ma	-	•	tment of F ificate of		nd Mental Hy	/giene Reg. No	000	00518
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	/Medic	al	4a. Facility Name (If not institution, give s	`	0		4b. City, Town, o	r Location of	Janua		, 200G County of Deat	0838 A M
	Examin	er	5) NO HOS P. 5. Social Security Number 6. Sex	al of	Bulf W	1016	Bu If Under 1 Year	LHW If Under 24	010			hplace (State or Foreign
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	he Ma	ecto	MD 10e, Street and Number		Baltim	ore	101 7: 0: 1:					1.☐Yes 2☐No
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212	filed withir Hygiene. ther than int, I're M	Completed	Elementary/Secondary (0-12) unk uni	College (1-4or 5+)	me. Do	O NOT use retire	2)				
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	1 and 2 Health a lem 27 is		Sinai Hospital					edere A	venue Bal	timo	re, MD	21215
lore	Pages 1 au nent of Hea int: If Item iry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R		20b. Place of cemetery		tion (Name of tory or other plac	ce)	Date	20c. Lo	ocation - City or	Town, State
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Ω_	res that thisigned by	by Ph	Part II. Other significant conditions con	tributing to death but	not resulting in	the und	erlying cause giv	en in Part I.	23e. Did	tobacco u	use contribute to	the cause of death?
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	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	edical C	29a. Certifier (Check only one) 1 Certifying Phys	ician: To the best of er: On the basis of e and manner state	examination and	death o	occurred at the tir stigation, in my o	ne, date and p pinion, death	place, and due to the occurred at the time,	cause(s) date and	and manner as I place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	2	11		29c. Licens			1	te signed (Month	
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			30. Name and address of person who co	NOI M	1)	44	19 F	7LLS	ROP	AL	70 M	115160
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06-0150 B.K.S Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend/Unpend item#19a,23a,27,28a i, penWi, 351,171/16 II
Th State of Maryland / Department of Health and Mental Hygiene MYRON WRIGHT 1 - For Stete Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Yee **Physician** Myron Mageo Wright 1055 A M 2006 6, JAN. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ST.AGNES HOSPITAL BALTIMORE CITY Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1**X** XI 2□ F Yrs. 219-52-6343 Director Sep 5, 1950 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Martical Expiritival must be notified at or 28a-f show **Baltimore** 1 Yes 2 No Maryland N/A Director 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 520 Lucia Avenue 21229 Be Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Xes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Warried 1970 1 ☐ Yes 2 XIO Maryland 21215-0036 Specify: Specify Black 3 ☐ Widowed 4 ☐ Divorced 1971 Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Painter 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be Mazie Wright Harold Wright 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Temsa Wright Wife 520 Lucia Avenue Baltimore, Maryland 21229 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 70 1 28 urial 2 ☐ Cremation 3 ☐ Removal from State = 5 permit. Page Department Important: If any injury or once. 01/17/06 Crownsville, Md 4 ☐ Donation 5 ☐ Other (Specify) Crownsville Veterans Cemetery 22. Name and Address of Facility Planeral Service Licensee 9 Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failurg. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Narcotic Intoxication /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physiclan/Medical Examiner Due to (or as a consequence of): nding physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ ate has been signing page 2 should be 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes director. 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient Y ER/Outpatient

28a. Date of Injury
(Month, Day Year)

28b. Time of Injury Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐Yes 2 ☐ No 28b. Time of Initial Certification: To DOA this 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation s after dea. 1/6/2006 1 ☐ Yes 2 ☐ No 2 Accident 6X Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5200 Lucia Ave 4 | Homicide 24 hours af Found in residence Baltimore, MD 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the within 2

Registrar DHMH 17 Rev 1/2001

State JAN 1

29b. Signature and title of certified

31. Date filed (Month, Day, Year)

ANMA111

30. Name and address of person who completed cause of death (Iten 23a) (Type, Print)

2008

29c. License number

O.C.M.E

PENN STREET, BALTIMORE, MARYLAND 21201

29d. Date signed (Month, Day, Year)

JAN.. 7, 2006

Physician /Medical Examiner

Depertment of H Important: if its any injury or ot once.

Physician

/Medical

Examiner

Director

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Pages 1 and 2 should be filed within 72 hours after nent of Heelth and Mental Hygiene. Int: if item 27 is marked other than "natural", or its

Baltimore, Maryland 21215-0036

nding physicien use as the burial

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physicien:

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Examiner IF FEMALE: 23b. Was decedent pregnant in the past 12 months? Yes 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 2 No 1 Yes 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of entifier 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MU Thomas 31. Date fifed (Month, Day, Year) 32. Registrar's Signatu 2006 2

State Registrar

		1	1 - For State Registrar	ate of Mar	yland / Depa <i>Cei</i>	artment of i			, ,	iene 2n) (5 (0521
. 50	Physic /Medi		1. Decedent's Name (First, Middle, Last) Sayvilla M. Bl	.oss			5		2. Date of Deat Month		Year	3. Time of Death
	Examir		4a. Facility Name (If not institution, give stree Joseph Ritchie Ho			4b. City, Town, Ba	or Location			4c. County	of Death	0.13pm
	Funeral Director		5. Social Security Number 6. Sex 1 - 07 - 7298	_	n yrs. last birthday) 37 Yrs.	If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Birth (Month, Day, 01/301	Year)	9. Birthp Cour	place (State or Foreign htry) MD
	faryland show	'n	Usual Residence of Decedent 10a. State MD 10b. County N/A	11	Oc. City, Town or Lo	cation Baltimo	ore C	ity			1	0d. Inside City Limits 11 Yes 2 □ No
	with the Maryland a or 28s-f show the nutified at	Director	10e. Street and Number 1451 Woodall St	reet		10f. Zip Code	2123		1	0g. Citizen of V	What Cour	
36	hours after death w tural', or items 23a	by Funerai	11. Marital Status 12. Never Married 25 Marned	Vas Decedent Evented Forces? Yes 2 No Yes, Give Year or Dates:		Was Decedent of f Yes, specify Cut	Hispanic Ori Dan, Mexican	igin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)		e - Americ k, White,	can Indian, etc. hite
1215-0036	"na	Completed	15. Decedent's Education (Specify only highest grade control of the specify only highest grade control of the specific of the	n npleted) College (1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire Homemak	during mos ed)	st of worki	ng	16b. Kind of Bu		dustry Home
Maryland 2121	be filed ntal Hygi of other	To Be Co	17. Father's Name (First, Middle, Last) Louis Smith				18. Mothe	_	(First, Middle, Nace Na	_		
	nd 2 alith a 27 is	-	19a. Informant's Name/Relationship (Type, 1 George Bloss /			ng Address (Stree Wooda 1						
Baltimore,	Pages 1 end 2 nent of Health int: If item 27 iny or other tre		20a. Method of Disposition 1 ★ furial 2 □ Cremation 3 □ Remo 4 □ Donation 5 □ Other (Specify)		20b. Place of Dispo Glen Ha	sition (Name of matory or other pla Ven Cen	Ja:		1,2006	Glen		
Balti	permit. Pages Department of Important: If is any injury or once.		21 Signature of Funeral Service 1 censee Vi	ctor P.	Doda C	Name and Addr harles 501 E.	ess of Facili L. S Fort	teve Ave	ns Fun Balt	eral H ımore	Home MD	Inc. 21230
	Physician /Medical Examiner	iner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. If any leasing to immediate cause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury that initiated eyents									Approximate Interval Between Onset and Death 2 years
8760, <	cate be executed physician end the burial-transi	dicai Examiner	c c c d	Due to (or as a c	onsequence of):						200	
.O. Box (that the death certifi ed by the attending I detached tor use as	Physician/Me	in the past 12 months?	yes, outcome of p □Live birth 2 [□Pregnant at tim □Unknown	Fetal death 3	Ectopic pregnand Other (specify)	су			23d. Dat Moi	te of delive	ory Day Year
Ω.	sign d be	by	Part II. Other significant conditions contribu	iting to death but r	not resulting in the u	nderlying cause gr	ven in Part I		23e. Did tob	_		ne cause of death?
Vital Records,	The law ate has b page 2 sh	Completed		• • • • • • • • • • • • • • • • • • • •					24a. Was ar autops perform 1 Yes 2	1ed?/	Were auto prior to co death?	psy findings available impletion of cause of
Division of Vita	l or Attending Physician: Thatler death. Director: Atter this certilicate I in by the funeral director, pag	Certification: To Be	2 Accident investigation	Ba. Date of Injury (Month, Day Yo	- At home, farm, str	28c. Inju Wc M 1	ther: 4 Number N	ursing Hon	TCheck only one 1 Check only one 28d. Describe ho 28f. Location (Str. City or Town	nce 6 Sother	ed	
厂	To the Hospital or Atte within 24 hours atter de To the Funerel Directo completely tilled in by th	Medical C	29a. Certifier (Check only one) 1 Certifying Physicia 2 Medical Examiner:	n: To the best of n On the basis of ex and manner stated	amination and/or in	n occurred at the t vestigation, in my	ime, date an opinion, dea	nd place, a th occurre	and due to the ca ed at the time, da	use(s) and ma ite and place, a	inner as si and due to	tated. the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier			29c. Licen	se number	275	58	JAN (
	5		30. Name and address of person who comple QUAN DONG NGUYEN			,	, , , ,		MOR F.			
	Sta Regist	_	31. Date filed (Month, Day, Year) JAN 1 3 200				/ 20					, .

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Blake Helen Loretta January 2006 10:05 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 3916 A Schroeder Avenue Perry Hall Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 15, 1921 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 🖫 F Director 220-07-2515 84 Maryland Usual Residence of Decedent filed within 72 hours efter deeth with the Maryland 10a State 10c, City, Town or Location 10h Counts 10d. Inside City Limits 77 is marked other than "natural", or Itame 23a or 28e-f ehow treumatic event, the Medical Examinar most be notified at 1 Yes 2 No Director Maruland Baltimore Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3916 A Schroeder Avenue 21128 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White. 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7; Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "na any injury or other treumatic event, Ite Madia once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 8th Grade Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Anthony S. Siecinski Katherine Kral 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Sandra Goscinski (daughter) 302 Tall Pines Court, Abingdon, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🖁 Burial 2 ☐ Cremation 3 ☐ Removal from State 1/13/2006 Baltimore, Maryland Stanislaus Cem. * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes Buan a. Will 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death End Stage Coronary heartdinean with Conquetive heart Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Pluxal 21001000 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner I Siabeter rullitur with ruropathy or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events ed by the attending physicien and detached for use as the burial-trar resulting in death) Last Due to (or as a consequence of): I vasculas disease Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by bowel Syndrome Lichemic 1 Yes 2 No 3 Probably 4 Unknown ortropasosis 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate has I perform Herer linidemic 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred after death. Director; After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide within 24 hours a To the Funeral I 1 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

A C. Churchallt, m D 29c. License number 29d, Date signed (Month, Day, Year, 2006 D16306 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MD 21236 BELAIR RD, A.C. CHOUVALIT, MD 9125 31. Date filed (Month, Day, Year) 32. Registrar's Signature State for the 2 2006 THE STATE OF THE S Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item# 4c, 2c, perFH, 351, 1/13/06 II 1 - For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year BARNETT 5 MAE) ILLLIE Linuary 2000 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 301 Staint Place BA BALTIMORE Year If Under 24 Hrs. MERCY MEDICAL CEWIER М÷ N/A Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 1 □ F Months Days Min. Hours 233-76-2125 59 Director 29,1946 Indiana Sept. Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28e-f ehow the Medical Exercitive must be notified at 1 Yes 2 No Maryland N/ADirecto Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 3722 Spaulding Avenue Funeral 21215 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or itema 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. I how 21 is marked other than "natural", or iter any injury or other treumatic event 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify: Specify: Black ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry New Psalmist Elementary/Secondary (0-12) College (1-4or 5+) Year Caterer Baptist Church 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Willie D. Barnett Evelyn Arnold 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 0 4 0 19a. Informant's Name/Relationship (Type, Print) 1975 Brookside Drive Edgewood, Maryland Eric Barnett/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 1/12/06 Woodlawn, May MD 4 □Donation 5 □ Other (Specify) King Memorial Park 21. Signature of Fineral Service Licenses 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md21215 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician LIVER FAILURE /Medical Due to (or as a consequence of): Examiner CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of. Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Crohas Box 68760, TB DUEASE Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) Records, P.O. the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 2 No 1 ☐ Yes 3 Probably 4 DUnknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? has 2 🗆 No 1 ☐ Yes 2 No 1 🗌 Yes Division of Vital : After this certifice e funeral director, (To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 1 patient ٩ 1 🗌 Yes 2**X** No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: completely filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerei I 29a Certifier i 📉 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) AU4176135515137 30. Name and add ess of person who completed cause of d tem 23a) (Type, Print) PANIL SHAH SATUT VINU 32 Aegistrar's Signature BALTIMORE KEYUR 31. Date filed (Month, Day, Year) State 2006 Registrar

P.O. Box 68760, Records, Division of Vital

1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** San 06 4b. City, Town, or Location of Death /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number Examiner Daltimore . 1 If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, 5. Social Security Number 6 Sax 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) 5. Social Security Number

220-36-7436

Usual Residence of Decedent **Funeral** 1 X M 2 □ F Mari Yrs. Director is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
Item 27 is marked other then "naturel", or Itame 23a or 28a-f show. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Maryland Funeral Director more 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 212 n9 aa 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status NYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify Specify: Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Id ocal 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Geneva reeman (Futher) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Walter xeatord 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 ₽ 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ö permit. Page Department of Important: If eny Injury or once. Bayview Cremator 4 □ Donation 5 □ Other (Specify) 22. Name and Address Pacility 21. Signature of Funeral Service Licenses Home Md. 21 Ss Funeral Ave. Balto 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shops, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician tagell /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner nding physicien and use as the burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Day Month 4⊡Pregnant at time of death 5 Other (specify) signed by the a 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24a. Was an 4b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 No certificate 1 Yes 1 🗌 Yes 20 No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 25 N 1 Impatient 2 ER/Outpatient 3 DOA this 27. Manne of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation within 24 hours after death.

To the Funerel Director: Af 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier (Check only one) 29b. Signature and title of confine 29d. Date signed (Month, Day, Year) 000 30. Name and address derson who completed cause of death (Item 23a) (Type, Print) ARINCI Adam Sinai мD 31. Date filed (Month, Day, Year) 32/Registrar's Signature 3 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 16 Rev 6/95

State Registrar 30. Name and address of person who completed cause of death (Item 23e) (Type, Brint)

2006

31. Date filed (Month, Day, Year)

outen

32. Registrer's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend items 12 20b per fh g851 1-13-06 vt
State of Maryland / Department of Health and Mental Hygiene. 06 Certificate of Death Reg. No:-1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** JANUARY 11,2006 11:400 Bernard Vincent Babka /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Saint Joseph Medical Center Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 01/01/1924 5. Social Security Number 6 Sax Birthplace (State or Foreign
Country) **Funeral** 1**X** M 2□ F Maryland Director 217-12-7106 Usual Residence of Deceden with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ir then "natural", or Iteme 23s or 28s-f show the Medical Exeminer must be notified at 1 ☐ Yes 2X No MD Harford Edgewood Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2301 Shannon Road 21040 U.S.A. death 12. Was Decedent Ever in U.S. Amped Forces? 1 Dyes 2 WW II Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: à 3 XWidowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4 12 Training Instructor U.S.Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fil ment of Health and Mental H tant: If Item 27 Is marked off Be 2 Vincent J. Babka Josephine V. Schultz 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

Date

Date

20c. Location - City or Town, State Mark Babka (son) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5 permit. Page Department of Important: If any injury or once. Metro Crematory, Inc. 1-12-06 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. E Jac 11750 Belair Road - Kingsville, Maryland saln Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final a SEVERE ISCHEMIC CARDIOMYOPATHY **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) signed by the a 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2/X No 3 ☐ Probably 4 ☐ Unknown Completed DYSPHAGIA page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No 20 No certificate Hospital or Attending Physician: After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury at Work? Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident Injury s after de. 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗍 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifie 29c. License number 06 D 37254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

BOON P.

31. Date filed (Month, Day, Year)

LIM M.D.

JAN 1 3 2006

ORIGINAL

2. Registrar's Signature

7601 OSLER DRIVE TOWSON MARYLAND 21204

		For State Registrar			Cei	rtificate	of D	eath			Reg. No:	UÜ	00527
Physicia	an	Decedent's Name (First, Middle, L MARY BRADFORD	ast)							2. Date of De	Day	Year	3. Time of Death
/Medic	al	4a. Fecility Name (If not institution, gi	ve street and numi	her)		4b. City, To	own or l	ocation o	f Death	JAN.		2006 ty of Death	7:15AMM
Examin	er	Ivy Hall Geriatr						Riv			1	timor	
Funeral			Sex 7	Age (In yrs. I		If Under 1		If Under 2		8. Date of Bir	28,1926		plece (State or Foreigr ntry)
Director		216-32-3671	1 □ M 2 X X F	79	Yrs.					Feb. 2	28,1926	Mar	yĺand
M H	}	Usuel Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
Hed a	to	Maryland Baltim	ore		Ba	altimo	re C	County	y				1 ☐ Yes 3√√No
hygiene hygiene do then 23a or 28a-f show do ther then "natural, or the Madical Examiner must be notified at	Director	10e. Street and Number				10f. Zip C					10g. Citizen of	What Cou	ntry?
23a		5 Walkway Ct.					2122		1.0.4		USA		
Item Der 77	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Deced	es?	S. 13.	Was Deceder If Yes, specify	nt of His y Cuban	panic Orig n, Mexican	in? (Spe , Puerto	ecify Yes or No Rican, etc.))- 14. He	ack, White	can Indian, , etc.
o la	by	3∕2 Widowed 4 □ Divorced	1 Tes 2 If Yes, Give Year or Dat	tes:		1□Yes X	X No	Specify:			Spec	ity: W	hite
netur lical	Completed	15. Decedent's l (Specify only highest g	ducation rade completed)		(Give	dent's Usual kind of work	done du	urina most	of worki	ng	16b. Kind of	Business/Ir	ndustry
Men a	mple	Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	<i>DO NOT us</i> e naker	retired)				Homem:	akina	-Own Home
ont, th		6th grade 17. Father's Name (First, Middle, Las	N/A		nullei	liaker.		18. Mothe	r's Name	(First, Middle	, Maiden Suma		OWN HOME
	To Be	Peter Shafer								hendara			
aumati	-	19a. Informant's Name/Relationship									er, City or Tow		p Code)
er tra		Shirley A. McKee	T (Dandh					Rd.			Md. 21		
If Item 27 is marks or other traumatic		20a. Method of Disposition X ☑ Burial 2 ☐ Cremation 3	□Removal from S	C	emetery, crei	natory or oth	er place		ء 1~13	ate 06	20c. Location		
) Inc		*4 □Donation 5 □Other (Spec	ify)	нот		1 Ceme		<u> </u>				·	
eny ir		21. Signature of Funeral Service Lic	2		22	Lassah 7401 P	n Fu	ir Rd	1 Ho	me ltimor	e, Md.	21236	
		23a art1. Enter the disease, or co shock, or heart failure. List on	mplications that ca	used the death									Approximate
ician		Immediate Cause (Final disease or condition	y one cause on ea	TAC	TAT	10	01	DN		ANIC	E12		Interval Between Onset and Death
dical		resulting in death)	Due to (o	or as e consequ	uence of):		~	- 0 / 4		MV C	-		
niner	_	Sequentially list conditions,	a. ME Due to (o Due to (o C. HY1	DHAV	24 /	427	ER	27 1	0/5	EAS			
nsit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	HV.	PICR T	TEN	5104							
burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (o	or as a consequ	uence of):	<i></i>	<i></i>						
ne par	cal		d										
d be detached for use as the		IF FEMALE:											
or use	by Physiclan/Medi	23b. Was decedent pregnant in the past 12 months?		th 2 Fetal	death 3	Ectopic pre						ate of deliv Month	ory Day Year
20	ysic	1 Yes 2 No	4□Pregna 9□Unknov	int at time of di	eath 5[Other (spec	offy)						
1	y Ph	Part II. Other significant conditions	contributing to dea	ath but not resi	ulting in the u	nderlying cau	ıse givei	n in Part I.		23e. Did	tobacco use co	ntribute to	the cause of death?
ed blu										10	Yes 2□No	3 🗆 Pro	bably 4 Dunknown
2 should	Completed									24a. Was		. Were aut	opsy findings available
page	mo									perfo	ormed?	death?	2 No
al director, page 2	BeC	25. Was case referred to medical examiner?							of Death	(Check only			-
10 10 10 10	은	1 ☐ Yes 2 ☐ No		patient 2	<u> </u>			4 Nu			idence 6 0		fy)
5	tion:	27. Manney of Death 1 Divatural 5 Pending 2 Accident investigat	,	n, Day Year)	28b. Time o Injury	M 286	c. Injury Work	at ? ′es 2⊡1		zoa. Describe	how injury occi	nited	
y the	fical	3 Suicide 6 Could not	be 28e. Place	of Injury - At he	ome, farm, st					28f. Location (Street and Nun	nber or Rui	al Route Number,
5 5 7	Certification:	4 Homicide	buildin	g, etc. (Specify	V)					City or Fo	wn, State)		
completely fillad in b			Physician: To the leminer: On the ba										
тр∮ө≀€	Medical	one)	and mann		without II	-		number	505411		29d. Date sign		
сотрів	4	29b. Signature and title of certifier	16	1	1 5	590	License		20	-	J / //	IN MONTH	, vay, roar)
		January and address of any	W/W	Of death /lto-	(D)	Print1) <u>/</u>	-110	10		-///	106	
4		Some and address of person wr	o completed cause	21	Mark	0-1	Var	e 6	an	Selle	MA	21	222
Sta		31. Date filed (Month, Day, Year)		gistrar's Signa	ture	•							
Regist	ar	JAN 1 3 20	06	see St	900	W)							
H 17 Rev 1/2			-										

			For State Registrar	State of Marylan		artment o			giene Reg. No. 06	00528
	* a		1. Decedent's Name (First, Middle, Last)					2. Date of De. Month	ath Day Yea	3. Time of Death
	Physici /Medio		Lillian	Bosley				January		0 0 - 14
	Examin		4a. Facility Name (If not institution, give s		_		m, or Location of De		4c. County of De	ath
ade 1			Mariner Health of			1	len Burni			Arundel
	Funeral	(20-20	5. Social Security Number 6. Sex		, ,	If Under 1 You Months Da		in (Month, Da	th y, Year) 9. B	irthplace (State or Foreign Country)
B	Director		217-10-7704	54.)2 Yrs.			Feb. 2	7 1913	MD
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits
	f aho	ō	MAryland Anne Ar	rundel			Glen Burr	ni o		1 ☐ Yes 2 ☐ No
	28a-	ect	10e. Street and Number	ander		10f. Zip Cod		iie	10g. Citizen of What (Country?
	Sa or	₫	7885 Gordon Court	Apt. 531			21060		USA	-
	72 hours after death with the Maryland naturel', or Items 23s or 28s-f show lital Exaturet must be notified at	Funeral Director		2. Was Decedent Ever in U	.S. 13.	Was Decedent		(Specify Yes or No lerto Rican, etc.)		nerican Indian,
ထ	If the		1 Never Married 2 Marned	Armed Forces? 1 ☐ Yes 2 🕱 No	i			ierto Hican, etc.)	Black, WI	nite, etc.
Ö	Pal.	٥	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 💢	No Specify:		Specify:	White
5-0	J within 72 hours after death with the Marylan jiene. r than "naturst", or Itams 23s or 28s-1 show the Mudical Examination at the indiffied at	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Dece	dent's Usual Od	ccupation one during most of i	working	16b. Kind of Busines	ss/Industry
21	within lene. then	дu	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use re	atired)			
2	Hygier Hygier Ithar th		8 17. Father's Name (First, Middle, Last)			aborato	ry Chemis		<u>Chemical</u>	Company
and	ed its b	Be	Walter Coll	inc				Name (First, Middle,		
Ž	should be ind Menta i marked umatic ev	2	19a. Informant's Name/Relationship (Type		10h Maili	ng Addrona (St	Edna		NNSON er, City or Town, State	Zin Code l
Maryland 21215-0036	s 1 and 2 should f Health and Men Item 27 is marks other traumatic		Archer Hilditch	76, Filmly				essadena,		, 21p Cdde)
	of Heal Item 2 other	(0)	20a. Method of Disposition	20b. F		osition (Name o	and the same of th	10.00	20c. Location - City	or Town, State
lo I	00		1 XBurial 2 ☐ Cremation 3 ☐ Re	BINOVALINOIN STATE		matory or other e1 Chur (n. ^{Date} 11 2006		
Baltimore,	コモモラ .		4 □Donation 5 □ Other (Specify) 21. Signature → Funeral Serves Lice see	and the same of th				the second secon	Pasadena, s Funeral	
Ba	Depa Impo any l		1 St.	1					dena, MD 2	
			23a. Part1. Enter the disease, or comolishock, or heart failure. List only on	cation with t caused the deat	h. Do not en					Approximate
			shock, or heart failure. List only of Immediate Cause (Final							Interval Between Onset and Death
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	Examiner				Gris conco		*			
		ē	Sequentially list conditions, if any, leading to immediate	. Due to (or as a consec	uence of):					
(uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							A.
o,	an ar rial-tı		resulting in death) Last	Due to (or as a conseq	uence of):					
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Ical								
9	ng ph as th	Physician/Med	IF FEMALE:							
Вох	eath certific attending p	an/I	23b. Was decedent pregnant	3c. If yes, outcome of pregna 1 Live birth 2 ☐ Feta		DEctopic pregn	ancy		23d. Date of c	
	e dea he at led fo	slcl	in the past 12 months? 1 □ Yes 2 □No 9 □ Unknown	4☐Pregnant at time of o		Other (specify			Month	Day Year
P.0	d by the deetached	Phy			Taller of the Atlanta			00 - Did.		
S,	res that signed to be det	þ	Part II. Other significant conditions con	unbuting to death but not res	uiting in the t	inderlying causi	e given in Paπ i.		_	to the cause of death? Probably 4 Munknown
O.	w require been si should I	etec	C 1	/ /	1 1-			-		
Records,	e taw has t	Completed	- Cerebrose	der Accio	rent			24a. Was	psy prior t	autopsy findings available o completion of cause of
H F	: The l	S						1 Yes	ormed? death 25/21No 1 □ Y	
Vital	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:		= -	Other	Death Check only		
of	Phys ral di	10	1 Yes 2 No	1 Inpatient 2	28b. Time of		4 Z-NUTSITI		dence 6 Other (S)	pecify)
O	ding F h. After funer	ton	1 SaNatural 5 Pending	28a. Date of Injury (Month, Day Year)	Injury	M 250.	Injury at Work? 1 ☐ Yes 2 ☐ No	250. 50001100	now injury occurred	
Division	Attending Physician: ar death. ector: After this certifics by the funeral director. I	flca	3 Suicide 6 Could not be	28e. Place of Injury - At h	ome, farm, st			28f. Location (Street and Number or	Rural Route Number.
á	after after Directory	Certification:	4 Homicide	building, etc. (Special	fy)	,,		City or To	wn, State)	
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Phys	Molan: To the best of my kn.	dwladga, dear	th securred at it	ne time date and pl	are, and due to the	rause(s) and mainle	as stated.
	n 24 I	Medical	(Check only 2 Medical Examination)	ner: On the basis of examina and manner stated.	ation and/or in	ivestigation, in i	my opinion, death o	ccurred at the time,	date and place, and d	ue to the cause(s)
	To the within 2 To the comple	ž	29b. Signature and title of certifier				cense number		29d. Date signed (Mo	
)	134.4		> Malchan	The The		D	-40521		January 1	0,2006
	1	-	30. Name and address of person who co	pleted cause of death (Ite	m 23a) (Type,	Print) 72	5 HOSPIT.	AL DRIVE	Suite 1	08
	0		DR. OCHANEJ			7	SIEN	BURNIE,	MD 2106	1
	St		31. Date filed (Month, Day, Year) AN 1 3 20	32. Registrar's Sign	ature	C	0		mo 2106	
3	Regist	rar	ALIN T 9 70	REPORTED .	St. All	THE SAL				

			1 - For State Registrar	State of M	aryland		rtment tificate			Mental Hy	giene	06	00529
34.1	Physic /Medi		1. Decedent's Name (First, Middle, Lillian	Marie H	Ball					2. Date of Do Month Janua	eath Day	Year 2006	3. Time of Death 6:50A.M
	Examir Funeral	ner	4a. Facility Name (If not institution, Stella Maris 5. Social Security Number 162-32-2732	Hospice		ast birthday)	Timo		nder 24 Hrs.		Ba	nty of Death altime 9. Birthp	OTE lace (State or Foreign
Stag	Director		Usual Residence of Decedent 10a. State 10b. County	1		Yrs.						Pen	nsylvania Od. Inside City Limits
	n the Man r 28a-f eh r colline	Director	Md . n /	'a		Balt	imor (10g. Citizen o	of What Cour	Yes 2□No
036	be filed within 72 hours after death with the Marylend ital Hygiene. d other then "naturel", or items 23a or 28a-f ehow event, itre Madical Examinar maral be notified at	by Funeral	1209 Limit A 11. Maritaf Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces?		f			Origin? (S dcan, Puert	pecify Yes or No o Rican, etc.)	US 14. R B	lace - Americ lack, White,	
d 21215-0036	filed within 72 ho Hygiene. Ather then "naturent, the Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12th 17. Father's Name (First, Middle, Li	grade completed) College (1-4or !	5+)	(Give life. L	ent's Usual (kind of work o OO NOT use AMS TT	doné during l retired) 2 S S		king ne (First, Middle	Se		Factory
Maryland	2 should be f and Mental is is marked of sumatic eve	To Be	Charles Willi	am Topper				Li	llia mberorRu	n Luci	Lle Ho	ckens m, State, Zip	Code)
Baltimore, M	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked eny Injury or other traumatic engoce.		Elaine L. Wag 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	B □Removal from State	20b. Pla	1209 ace of Disposementary, crem acula	sition (Name natory or othe	of er place)		Date	20c. Location	n - City or To	wn, State
Balti	permit. Popartm Departm Importar eny Injui		21. Signature of Funeral Service Li	consee m	0093	3 ²² 3(Name and A	Address of Fa	way V	iser Fi Vest Ne	uneral ew Oxf	Home	Pa.17350
1.	Physician /Medical Examiner		23a. Part1. Enter the dise S. or c shock, or heart failure. List or fmmediate Cause (Finaf disease or condition resulting in death)	a. <u>CERVIC</u> Due to (or as	^{ne.} AL_CAN	ICER	or the mode o	t dying, such	as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
8760,	icate be executed physicien and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as									
.O. Box 68	death certif e attending od for use as	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	23c. ff yes, outcome 1 Live birth 4 Pregnant at	2 Fetal o	death 3 🗌	Ectopic pregi Other (speci					Date of delive Month	ry Day Year
rds, P.	The law requires that the site has been signed by the page 2 should be detache		Part II. Other significant condition	s contributing to death b	ut not resul	ting in the un	derlying caus	se given in Pa	art I.	_			e cause of death?
		Completed								24a. Was autor perfo	rmed?	death?	osy findings available aptetion of cause of
₹	Physician: rthis certific ral director,	o Be	25. Was case referred to medical examiner?	Hospital:		510		O#		th Check only o			
sion of	Attending Phy ir death. ector: After this by the funeral d	Certification; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investiga	28a. Date of Inju (Month, Da		P/Outpatient 28b. Time of fnjury		tnjury at Work? 1 Yes 2		ome 5 ☐ Resident 28d. Describe			HOSPICE
Dİ <u>X</u>	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: Alier th completely filled in by the funeral		3 Suicide 6 Could no determin	ed 28e. Place of Influence building, etc	c. (Specify)					City or Tou	vn, State)		Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in It.	Medical	29a. Certifier (Check only one) 29b. Signature and title of certifier	Physician: To the best taminer: On the basis of and manner sta	examination	ledge, death on and/or inv	estigation, in	he time, date my opinion, o cense numb	death occur	red at the time,	cause(s) and n date and place 29d. Date sign	, and due to	the cause(s)
)	V		1 /1-		11 (1)		D	4372	5		1//	1/06	
	4		30. Name and address of person with				,	marc	MTIPE	MD 010			
ţ,	Sta	te	31. Date filed (Month, Day, Year)	OD 2300 DT 32. Registra			SY KD.	TIMO	MLUM,	MD 210	7.3		
100	Registr	ar	JAN 1 3 2	1006	. H.	Cos	de						

		1 - For State Registrar	State of Marylan		artment rtificate			ind M		Reg. No.	06	00530	- Aller
Physici	an	1. Decedent's Name (First, Middle, Last, Hyun Ba							2. Date of De Month	Day	Year	3. Time of Death 8:20 a.m.	
/Medic Examir		Hyun Ba 4a. Facility Name (If not institution, give			4b. City.	Town, or	Location o		Januai		O , 200 County of Deat	7 9	_
Exami	iei S	5308 Dunteachi			E11	ico	tt C	ity			Howar	r d	
Funeral		5. Social Security Number 6. Security Number 1.	IN SME		If Under Months	1 Year Days	Il Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	rth ay, Year)	9. Birt	thplace (State or Fore	ig
Director		226.25.0001 Usual Residence of Decedent	7	7 Yrs.				s	eptember	16, 19	28	Korea	
yland		10a. State 10b. County	10c. City	y, Town or Lo	ocation							10d. Inside City Limi	
Ba-f s	Director		ward	Elli	Cott							1 ☐ Yes 2 🔀 1	40
with the	Dire	10e. Street and Number			10f. Zip	Code	, 210	12		10g. Citize	en of What Co	ountry? S.A.	
ns 23	Funerai	5308 Dunteachin Drive	12. Was Decedent Ever in U.	S. 13.	Was Deced	dent of Hi			ecify Yes or No Rican, etc.)	0- 14	4. Race - Ame		_
after or itar	Fur	1 Never Married 2 Married	Amed Forces? 1 ☐ Yes 2 X No If Yes, Give			offy Cuba	n, Mexican Specify:	, Puerto	Rican, etc.)	1	Black, White	e, etc.	
ural',	d by	3 Widowed 4 Divorced	Year or Dates:								Specify:	Asian	_
filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Itams 23a or 28a-f show ent, the Madical Examiner must be notified at	Completed	15. Decedent's Edu (Specify only highest grad	e completed)	(Give	dent's Usua kind of wor DO NOT us	rk done d	turina most	of worki	ng	16b. Kind	d of Business/	Industry I home	
d with giene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+)			hom	e make	er			OWII	Home	
sal Hygenthe	Bec	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name	(First, Middle	, Maiden S	Sumame)		
should be nd Mental marked c	은		nik Shin	401 44 11		(2)				Bo Bae		7.0.11	_
d 2 st th and t7 is n traun		19a. Informant's Name/Relationship (T)							ott City, M			ip Code)	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Itams 23a or 28a-1 show any injury or other traumatic event, the Madical Examiner must be notified at once.		Ms. Esther Choi 20a. Method of Disposition	_	Place of Disposemetery, cre	osition (Nan	ne of			ate		ation - City or	Town, State	
Pages nent of int: If It iry or o		1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	removal from State	_	al Mem			01/1	14/2006	F	alls Chur	rch, Virginia	
Physician /Medical Examiner bhysician and bhysician and strength to the private transit	edical Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ilications that Raused the death ne cause on each line. a. A Zehi m Due to (or as a consequence) uence of):	Dvz	le ol dyin	g, such as	cardiac c	P.A. Dike Ellico or respiratory a	arrest,		Approximate Interval Between Onset and Death		
wrequires that the death certifica been signed by the attending ph should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1□Live birth 2□Feta 4□Pregnant at time of d 9□Unknown	l death 3	⊒Ectopic pr ⊒ Other (sp					23	3d. Date of del Month	livery Day Year	
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The larate has	Completed								24a. Was auto perf 1 Tes	ormeg?	prior to death?	utopsy lindings availal completion of cause o	ble
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ding h. After fune	1-	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injun Worl	y at ⟨? Yes 2□I		28d. Describe			City)	
	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	(y) 					City or To	iwn, State)		ural Route Number,	
To the Hospital or within 24 hours after To the Funeral Director Completely filled in	Medical	29a. Certifier 1 Certifying Phy (Check only one)	rsician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, dea ation and/or i	th occurred nvestigation	at the tin	ne, date an pinion, dea	d place, th occurr	and due to the ed at the time	, date and p	place, and due	e to the cause(s)	
To the twithin 2. To the I complet	Σ	29b. Signature and title of certifier	in a		290	c. License	number			29d. Date	signed (Mont	h, Day, Year)	
(28		1)	2569	54		/_	10/06		
5		30. Name and address of person who o	completed cause of death (Item	n 23a) (Type	Print)		GV	2	ml	,			
St	ate	31. Date filed (Month, Day, Year)	22. Registrar's Signa	ature									-
Regist	rar	JAN 1 3 2000	5 Karter S.	100	Cind .								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#5, perFn 2851 1/17/06 TT. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 0340 AM AN 2006 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) University of Maryland Medical Center Baltimore City Baltimore If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
Oct 13, 1931 Social Security Number 6 Sex Days Hours 1 M 2 XX 212-18-6227 MD 74 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10h County 1 ☐ Yes 2 No MD Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7959 Telegraph Rd Lot 27 21144 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: Specify: White 3XXVidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Coilege (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Elsie A. Widerman Clarence F. Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 298 B Mountain Ridge Ct, Glen Burnie, MD 21061 William Coen Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Slate 1 Removal from State 2 □ Cremation 3 □ Removal from State Maryland Nat'1 Cemetery 1-16-06 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility D A

Important: If Item any Injury or other Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

rel', or itema 23a or 28a-f show Examiner must be notified at

Director

Funeral

Completed by

with the Maryland

Baltimore, Maryland 21215-0036

physician and s the burial-transit

signed I

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

K. Cresory Fig.	ık → M01148	,		•	. MD 2	1061
23a. Part Lenter the dise, se, ir comp shock, heart hillur. List only of Immediate Cause (Finat disease or condition resulting in death)	one cause on each line. a. Intracerel	boal her	ode of dying, such as cardia	c or respiratory arrest,		Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	,				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal	I death 3 Ectopic			23d. Date of dei Month	ivery Day Year
Part II. Other significant conditions of Renal Failure		the cause of death?				
				24a. Was an autopsy performed?	prior to death?	itopsy findings available completion of cause of 2 No
25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)		
1 ☐ Yes 2 No	Hospital: 15 Inpatient 2	ER/Outpatient 3 🗆 🗆	OOA Other: 4 Nursing I	Home 5 Residence	6 ☐Other (Spe	city)
E _ Accident		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inj	ury occurred	
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho	ome, farm, street, facto	ry, office			ural Route Number.
29a. Certifier (Check only one) 158 Certifying Ph	y sician : To the best of my kno niner: On the basis of examina and manner stated.	wledge, death occurre tion and/or investigation	d at the time, date and placen, in my opinion, death occ	e, and due to the cause(urred at the time, date a	s) and manner as nd place, and due	s stated. to the cause(s)
29b. Signature and titler of pertiller	ZM.D.	2:	9c. License number #(S8(8	JA	ate signed (Mont.)	n, Day, Year) 2006
	23a. Part Lenter the disc. se, ir c.m., shock, heart hilure. List only of mmediate Cause (Finat disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	shock, heart hatur. List only one cause on each line. Immediate Cause (Finat disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in death Disease of Injury (Month, Day Year) 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 27. Manner of Death Route of Could not be determined Disease of Injury (Month, Day Year) 29a. Certifler (Check only one) Certifying Physician: To the best of my known and manner stated.	23a. Part Inter the dise, se, if complications that caused the death. Do not enter the moshock, heart halture. List only one cause on each line. Immediate Cause (Finat disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23a. Part I Enter the dise se, iric mplications that caused the death. Do not enter the mode of dying, such as cardia shock, heart future. List only one cause on each line. Immediate Cause (Finat disease or condition resulting in death) Interest of the cause of the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due	23a. Part Enter the disease. If complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart heart sure. Lit orly one cause on each line. Immediate Cause (Final disease or condition resoluting in death) Sequentially list conditions, if any, leading to immediate cause. Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25c. Was case referred to medical examiner? 1 Yes 2 No 2 N	23a. Part Tenter the dise, see of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line. Immediate Cause (Final disease) Immediate Cause (Final disease) Sequentially list conditions if any, leading to immediate Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence

State Registrar DHMH 17 Rev 1/2001

within 24 hours after To the Funeral Dire

31. Date filed (Month, Day, Year) 32. Pogistrar's Signature

no completed cause of death (Item 23a) (Type_Print)

30. Name and address of person

MARK IGUCHI, M.O. 22. South Greene Street, Baltinoie, Mayland, 2120

		1- State Registrar/Amend Item #1 Per PHY G851 19	partment of Health and Mental	Hygiene 06 00532
Physici /Medic Examir Funeral Director	al	1. Decedent's Name (First, Middle, Last) Alexander Constitution of the Alexander Constitution o	OUSININ, Jr. 4b. City, Town, or Location of Death BALTIMORE MO (ay) If Under 1 Year If Under 24 Hrs. 8. Date Months Days Hours Min. 8. Months (Months)	4c. County of Death BALTIMORE CITY
ife after death with the Maryland or items 23s or 28s-f show infree must be notified at	/ Funeral Director	1 ☐ Never Married 2 🕅 Married 1 💢 Yes 2 ☐ No	Milford 10f. Zip Code 19963 13. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et	10d. Inside City Limits 1 □ Yes 2 [X] No 10g. Citizen of What Country? USA or No- c.) 14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036 at 2 should be lifed within 72 hours after the and Mental Hygiene. The merked other than "natural", or its treumatic avant, the Madical Examina	Be Completed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	ecedent's Usual Occupation sive kind of work done during most of working fe. DO NOT use retired) Post Master 18. Mother's Name (First, M.)	16b. Kind of Business/Industry Postal Service
re, Marylan s 1 and 2 should be 1 Health and Mental Itam 27 is marked of	ToB	19a. Informant's Name/Relationship (Type, Print) 19b. M	Mary K Hailing Address (Street and Number or Aural Acute N 7106 Turtle Hill Road, M	
0 90 = 5		20a. Method of Disposition 1 🖾 Buriat 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Sharon	isposition (Name of crematory or other place) Hills Mem. Pk Date 14 2006	20c. Location - City or Town, State Dover, Delaware
Baltim permit. Par Department important: any injury once.		23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	3111 Mountain Road, Pa	
Physician /Medical Examiner As prize transit per prize transit pe	ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		Onset and Death
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ords, P. oquires that the signed by ould be detected	ed by Ph	Part tl. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I. 23e.	Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Monower
	Completed		24a.	Was an autopsy available prior to completion of cause of death? Yes 2 № No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
C G tig	Certification: To Be	25. Was case referred to medical examiner? 127. Manner of Death 128. Naturat 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	ne of 28c. Injury at Work? M 1 Yes 2 No 28f. Loca	only one) Residence 6 Other (Specify) cribe how injury occurred tion (Street and Number or Rural Route Number, or Town, State)
Hospita 4 hours Funaral tely fillec	Medicai Cer	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, of the basis of examination and/or and manner stated.	feath occurred at the time, date and place, and due to prinvestigation, in my opinion, death occurred at the	o the cause(s) and manner as stated. time, date and place, and due to the cause(s)
To tha within 2 To the complet	Me	29b. Signature and title of certifier Pinentel, MD	29c. License number D 40 363	Jan 12, 2006
b	10	30. Name and address of person who completed cause of death (Item 23a) (Ty Laura Pinchtel 1 31. Date filed (Month, Day, Year) 32. Registrar's Signature	301 St. Paul Place	, Balt. Md.
Sta Regist		JAN 1 3 2006	Sparle .	

			1 - For State Registrar	State o	f Marylar		artmen rtificat			and M		leg. No.	006	0053	3	
į	Physici /Medic		1. Decedent's Name (First, Middle, Wilmer H. Cr								2. Date of Dea Month January	Day	2006 Year	3. Time of De 4:00A		
***	Examin		4a. Facility Name (If not institution, g	give street and nu	mber)			Town, or	Location o	f Death	-	4c.	County of Dea			
16. The state of t	Funeral Director		5. Social Security Number 6 203-16-0256	.Sex 1ĂM 2□F	7. Age (In yrs. 8.		If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Day Nov. 1	Year)	9. Bi	rthplace (State or F ountry) nnsylvani	oreign a	
	hours after death with the Maryland turel', or iteme 23e or 28e-f ehow al Examinar must be natified at	Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Montgo: 10e. Street and Number			ity, Town or Lo	pring 10f. Zip					_	zen of What C	•		
0036	be filed within 72 hours after death with the Marylar Ital Hygiene. Id other than "naturel", or itame 23a or 28e-1 ehow avent, the Madical Examinat must be notified at	by	12500 Feldon St 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deci Armed Fo 1 X Yes If Yes, Gi Year or D	2□No 19	943-	Was Decedif Yes, spec	dent of Hi cify Cuba 2 No	Specity:	gin? (Spe , Puerto	acify Yes or No- Rican, etc.)		Black, Wh	. Race - American Indian, Black, White, etc.		
Maryland 21215-0036	rithin 72 ne. han "na	Be Completed	15. Decedent's (Specify only highest the Elementary/Secondary (0-12) 17. Father's Name (First, Middle, La	grade completed) College (4	1-4or 5+)	(Give	kind of wo DO NOT us	rk done d se retired,	uring most Spe	cial		Fe	deral (Governmen	t	
arylan	2 should be filed w n and Mental Hygien is marked other ti reumatic avent, Ib	To B	Herbert W. Cre			19b. Mailir	ng Address	(Street a			a Dotte		r Town, State,	Zip Code)		
Baltimore, Ma	permit. Pages 1 and 2 should Department of Health and Men Important: If Itam 27 is marke any injury or other treumatic Quee.		Robert J. Cress 20a. Method of Disposition 1 \(\tilde{\Delta}\) Burial 2 \(\tilde{\Delta}\) Cremation 3 4 \(\tilde{\Delta}\) Donation 5 \(\tilde{\Delta}\) Other (Spe 21. Signature \(\tilde{\Delta}\) al Service Lic	☐Removal from cify)	State Ar	Place of Disponder Cemetery, cres	natory or on Nat	ne of other place iona) M	arch 006		20c. Lo	ington,			
· ·	Physician /Medical Examiner		23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a. An	caused the dealer can be considered to the dealer can be conserved as a conserved to the case of the c	ncephal quence of):	er the mod	e of dying						Approximate Interval Betwe Onset and De	en	
8760, 存	te be executed ysicien and e burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):													
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al Records,		Completed									24a. Was autop perfor 1 🗆 Yes	sy med?	prior to death?	utopsy findings ava completion of causes s 2 \(\text{No} \)	ailable se of	
Division of Vital	nding Physician: Thath. Ath. T: After this certificate e funeral director, pag	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 XNo 27. Manner of Death 1 Natural 5 Pending investigal	28a. Date (Mon		ER/Outpatier 28b. Time of Injury		8c. Injury Work	er: 4X Nu	rsing Hoi	n <i>(Check only</i> o me 5 Resid 28d. Describe h	ence (ecify)		
Divis	To the Hospitel or Attending Pl within 24 hours after death. To the Funerel Director: After the completely filled in by the funera	Certification:	3 Suicide 6 Could no 4 Homicide determine	288. Place	of Injury - At h	nome, farm, str	reet, factor	, office			28f. Location (S City or Tow			Rural Route Numbe	r,	
	the Hospi nin 24 hour the Funer npletely fill	edical	(Check only 2 Medical Ex	Physicien: To the taminer: On the band man	best of my kn asis of examin ner stated.	owledge, deat ation and/or in	vestigation	, in my op	pinion, deat	d place, a	ed at the time, o	date and	place, and du	e to the cause(s)		
)	with	M	29b. Signature and title of certifier	D(0)	110	/		D050					e signed (Mon uary 10	, 2006		
8	13+1 Sta	ite_	30. Name a daddr s of person who Godswill O. Ok. 31. Date filed (Month, Day, Year)	oji, M.D	. 1809 Registrar's Sign	Benni	ng Ro	ad,	N.E.,	Was	hington	, D.	.C. 20	002	1:	
	Registi	ar	JAN 1 3 200	6	a Af	Doors	20									

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. Ne. U Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** RAYMOND PAUL DOVE 8:30 pM January 6, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Laurel Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F Months Days Director 578-10-3066 88 March 15, 1917 Washington, DC Usual Residence of Deceden with the Maryland 10b. County 10c City Town or Location 10d. Inside City Limits worle 10a State the Medical Examiner must be notified at 1 Tes 2 No Prince George's MD Director Laurel 28a-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 or iteme 23a 9268 CHerry Lane #62 20708 U.S.A. death Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 2 des 2 \(\text{No} \) 1942 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. e filed within 72 hours after all Hygiene Instruction of her then "naturel", or item 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates: ð 3 ☐ Widowed 4 ☐ Divorced -1945White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Grade 12 Letter Carrier U.S.P.S. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, es 1 and 2 should be fi of Health and Mental H I item 27 is marked of Lester Linwood Dove Ellen Isabell Fallow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Hollar cousin 8718 Crest Road Severn, Maryland 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Peges 1
Department of H
Important: If its
eny Injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State Ft. Lincoln Cemetey Jan 11, 2006 4 □ Donation 5 □ Other (Specify) Bladensburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. / M00770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Listjonly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sepsis 1 day disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Dementia 5 years Sequentially list conditions, if any learning time and cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine certificate be executed attending physicien and for use as the burial-transit Type 2 Diabetes 5 years that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, À 1 ☐ Yes XX No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? The law autopsy performe 2**XX**0 1 Yes 2XXNo 1 Yes Division of Vital To the Hospitel or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2XXVo 1 Inpatient XXER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) After thi 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1XXIatural 5 Pending 1 ☐ Yes 2 ☐ No investigation M 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Cartifying Physicien: To the best of my knowledge death concred at the time date and stand, and due to the nause(s) and manner as stated 29a Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) 29c. License number Par D 43237 January 8, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Armstrong, M.D. 14201 Laurel Park Drive #102 Laurel, Maryland 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JAN 13 2008 Registrar

			For State Registrar		State of Ma	aryland		artment tificate			Mental F	lygier Reg. i	_000)	0053	35
3	Physicia /Medic		1. Decedent's Name	e (First, Middle, La: E. DUN							2. Date of Month		Day	Year LOO6	3. Time of 5:58	
	Examin			f not institution, give	e street and number)			_		Location of Dea	th		4c. County o			
26	Funeral Director	•	5. Social Security N 313-66-2	lumber 6. S		je (In yrs. ias 48	st birthday) Yrs.	If Under Months				Birth 15,1	957	9. Birth	place (State of ntry) Iana	r Foreign
0	D. M.		Usual Residence of 10a. State	Decedent 10b. County		10c. City,	Town or Lo	cation							10d. Inside Cit	ty Limits
Z	eme 23a or 28a-f show	ctor	Maryland	Anne A	rundel		Pasad	ena							1 🗍 Yes	2 No
di di	or 28	Funeral Director	10e. Street and Nur					10f. Zip		10		10g.	Citizen of WI		ntry?	
t to	Iteme 23a	eral	7777 Not.	iey koad	12. Was Decedent	Ever in U.S.	13. \	Nas Deced	2112 ent of Hi	spanic Origin? (n, Mexican, Pue	Specify Yes or	No-		- Americ	can Indian,	
Maryland 21215-0036	ral', or ite	þ	1 Never Marri	ied 2 Married 4 Divorced	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:			f Yes, spec		Specify:	rto Rican, etc.)		Specify:	B1a		
15-0	yene. yene. r than "natural" the Medical Ex	ietec		15. Decedent's Early only highest gra	ade completed)		16a. Deced (Give	lent's Usua kind of wor DO NOT us	k done d	turing most of we	orking	16b	. Kind of Bus	iness/In	ndustry	
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pu	ntal Hygind other	Be	17. Father's Name)					18. Mother's Na	me (First, Mid	dle, Maio	len Sumame)		
ryla Ferri	z should be no and Mental I is marked of raumatic eve	မှ	Phi	1 ame/Relationship (Redd Type Print)		19b Mailir	n Address	(Street a	E11a	May Car		tv or Town S	tate 7i	n Code)	
imore,	reges rend nent of Health ant: If Item 27 ury or other t		20a. Method of Disp 1 Burial 2 4 Donation	position Cremation 3 5 Other (Specif		Ceri	nhill	Ceme	tery	01-	urt, G] 17-06				ryland own, State	
Bal	Departr Departr Import eny In		21. Signature of Fu	pregal Service Lice	nsee)	(1)				ss of Facility yniak F iin Road	uneral	Home	P.A.	1	01100	
	hysician /Medical		23 Part 1. Enter the shock, or heal Immediate Cause disease or condition resulting in death)	(Final	plications that cause one cause on each li	15	Do not ent	or the mod	e of dying	IIN KOAO g, such as cardia	, Pasade	y arrest,	Maryla		Approximate Interval Betto Onset and I	ween Death
8760, ×	physicien and the burial-transit	dical Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death) i	injury	Due to (or as	a conseque	nce of):	RIAN	C	HNCER					3MON	THS
P.O. Box 6	I o the hospital of Attending Priystolen: The law requires thet the oeath certain with 24 hours after death. Anithin 24 hours after death. To the Furnetal Director: After this certificate has been signed by the attending p. completely filled in by the funeral director, page 2 should be detached for use as a completely filled in by the funeral director, page 2.	Physician/Me	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 25 9 Unknown	months? ☑No	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetel d	leath 3	Ectopic pr Other (sp					23d. Date Mon		,	Year
G. 9	es mer igned b be deta	by P	Part II. Other signif		contributing to death t	out not result	ing in the u	nderlying c	ause give	en in Part I.	23e. C	id tobacc	o use contril	oute to f	the cause of d	eath?
ord	been si should t	ted	CORON			ISEAS	E				1	☐ Yes	2 € No :	3 Prol	bably 4 □l	Jnknown
Division of Vital Records,	ysicien: The law is certificate has b director, page 2 st	Completed	· HYPE	ERTENSI	0 N						24a. V a p 1 🗆 Ye	utopsy erformed	2 pr	or to co	opsy findings omptetion of co	available ause of
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J of	After this funeral di	 -	27. Manner of Deat	th	28a. Date of Inju	IN 2	8b. Time of		8c. Injury Work	4 Nursing	Home 5 F		njury occurre		ry)	
sior	tendin death. tor: Aft the fun	catio	1 Natural 2 Accident	5 ☐ Pending investigation 6 ☐ Could not be	n	,,,,,,,	,	М		Yes 2 □ No						
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3	To the Hospital or Avithin 24 hours after of To the Funeral Direct completely filled in by	edicai	29a. Certifier (Check only one)	1 Certifying Pl 2 Medical Exa	nysician: To the best miner: On the basis of and manner st	of examination	ledge, deatl on and/or in	n occurred vestigation	at the tim , in my op	ne, date and place pinion, death occ	ce, and due to curred at the tir	the cause ne, date	e(s) and man and place, ar	ner as s nd due t	stated. to the cause(s	.)
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	,/			imusa	completed cause of		23a) (Tuna		,53	301		JAN	IUAKY	10	2006	
	Sta			NOZEN.	YUY NTAT	rar's Signatu	HAR	BOR	Hos	SPITAL						
DHM	Registi		JAN	1 3 2006	Beeres	M.	Good									

			For Stete Registrer		partment of Health and leartificate of Death	Mental Hygiene	HILL HUDSO
			Decedent's Name (First, Middle, Las	1)		2. Date of Death	3. Time of Death
	Physici /Medio		Mary	Dave	aport	JANUARY 1	2006 10:00 AM
A	Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Deat		County of Death
1			401 BAYLOR Kd 5. Social Security Number 6. Se	ex 7. Age (In yrs. last birthd	(S) BURNIE av) If Under 1 Year If Under 24 Hrs		9. Birthplace (State or Foreign
	Funeral Director			JM 210 F 82 Yrs	Months Days Hours Min	(Month, Day, Year)	Country)
			Usual Residence of Decedent			3019 17,112	
	ehow	'n	10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the M	ecto	10e. Street and Number	PRUNDE GIEN	BURNIE 101. Zip Code	10g Cit	izen of What Country?
	With 3a or	iDir	12.	Road	71061		·S.A·
	deeth	Funeral Directo	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl		14. Race - American Indian,
9	hours after deeth with the Maryland lurel, or Iteme 23e or 28e-f ehow al Examinat must be notified at		1 Never Married 2 Married	1 ☐ Yes 2 ☑ No	1 Yes 2 No Specify:	o Rican, etc.)	Black, White, etc.
21215-0036	hours tural',	ed by	3 ☐ Widowed 4 ☑ Divorced	Year or Dates:			While
5	in 72 n "nat	Completed	15. Decedent's Ed (Specify only highest grad	de completed) (G	ecedent's Usual Occupation ive kind of work done during most of wor e. DO NOT use retired)	king 166. K	ind of Business/Industry
212	led within ygiene. her then "	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	MASTER OFFICE CE	shiER W	DESTINGHOUSE
	# I # F	Be (17. Father's Name (First, Middle, Last)	0 1	18. Mother's Nar	ne (First, Middle, Maiden	Sumame)
yla	D 2 2 5	ဥ	1 headore	PAPAILA	PELAC		OPIR
Maryland	d 2 shou th and M 7 ie mar traumat		19a. Informant's Name/Relationship (7) Michael Chanat		ailing Address (Street and Number or Ru	-	A . A
-	f Heall item 2 other		20a. Method of Disposition	- NEPhEW 421 20b. Place of Di	Boylor Rd. Glesposition (Name of		cation - City or Town, State
Baltimore	8°= 5		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	A GARDENS JAN.	13, 2006 EIK	eida = Maculand
alti	Frank "		21. Signature of Funeral Service Licen		22. Name and Address of Facility		
<u> </u>	Depa impo eny i		Grand no		4001 Ritchie Hu	y. BAlto.	MARYLAND ZIZZS
П				ilications that caused the death. Do not one cause on each line.		or respiratory arrest,	Approximate Interval Between Onset and Death
)	Physician		Immediate Cause (Final disease or condition resulting in death)	a. ATheroscl	erote Hear	T Discos	e junediate
	/Medical Examiner		1	Due to (or as a consequence of):			
		er	Secuentially list conditions if any, leading to immediate	b. Due to (or as a consequence of):			
H	cuted nd ransli	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	С.			
, 0,	rate be executed hysicien and the burial-transli		resulting in death) Last	Due to (or as a consequence of):			
8760,	cate t	edical		d			
Box 6	The law requires that the death certificate sie has been signed by the attending physoage 2 should be detached for use as the	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy		1	23d. Date of delivery
	death	Physician/M	in the past 12 months?		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year
P.0	at the de	Phys	9 Unknovin				
	ires that signed to be det	by	Part II. Other significant conditions co	entributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco u	se contribute to the cause of death?
örc	w require been sig should b	etec					
Rec	The lav sete has page 2	Completed				24a. Was an autopsy performed?	24b. Were autopsy lindings available prior to completion of cause of death?
ta		e C	25. Was case referred to medical		26 Place of Dec	th (Check only one)	1 ☐ Yes 2 ☐ No
Ž	Physicien: this certificanal director, I	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	100-		3 □Other (Specify)
0 0			27. Manner of Peath Natural 5 ☐ Pending	28a. Date of Injury 28b. Time (Month, Day Year) Injury	e of 28c, Injury at	28d. Describe how injur	y occurred
sio	feat	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		M 1 ☐ Yes 2 ☐ No		
Division of Vital Records,	i 2 at 2	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	281. Location (Street an City or Town, State	d Number or Rural Route Number,)
	To the Hospital or At within 24 hours effer or To the Funerel Direct completely filled in by		29a. Certifier	ysicien: To the best of my knowledge, de	eath occurred at the time, date and place	, and due to the cause(s)	and manner as stated.
	the Ho nin 24 the Fu npletel	Medicai	(Check only 2 Medicaf Exem	iner: On the basis of examination and/or and manner stated.	r investigation, in my opinion, death occu	rred at the time, date and	place, and due to the cause(s)
	To To To To To To To To To To To To To T	Σ	29b. Signature and title of certifier	8 2 1 11 -	29c. License number	4	e signed (Month, Day, Year)
•	4		muye 6	sores mo	0 2 1 7 3 8	- Jan	nary 11,2006
	0		30. Name and address of person who of Mayer Garba	completed cause of death (Item 23a) (Type 7 9 7 9	9 quahart 200	1660 R	USAIR MO 21011
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signature	1 7	4 CIEUD	d, 116, 12
	Registr		JAN 1 3 2006	Branch M. Again	de)		
DH	MH 17 Rev 1/2	001					

			For State Registrar	State of Maryla		artment of F			giene neg. No. 006	00537
	Â	ż	1. Decedent's Name (First, Middle, La	st)				2. Date of Dea	th Day Yea	3. Time of Death
	Physici: /Medic		Jerry William D	eLawter				January		3:46P M
	Examin	er	4a. Facility Name (If not institution, given			4b. City, Town, o	r Location of Death		4c. County of De	ath
		S 5	Shady Grove Adve		last birthday)	Rockvill	Le If Under 24 Hrs.	8. Date of Birt	Montgom	ery inthplace (State or Foreign
	Funeral Director			1⊠M 2□F 70	Yrs.	Months Days	Hours Min.	(Month, Day Aug. 27	, 1935 Wa	shington, DC
	ס		Usual Residence of Decedent							
	show	<u>_</u>	10a. State 10b. County		ity, Town or Lo	cation				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	Ba-f	ecto	Maryland Montgome	ry Roc	kville	104 75- 0-4-			10-08	1
	72 hours after death with the Maryland Insturel, or items 23s or 28s-f show blost Examinations and be multified at	Funeral Director	10e, Street and Number			10f. Zip Code		4	10g. Citizen of What (
	eath	era	100 Deep Trail L	12. Was Decedent Ever in U	J.S. 13. V	20850 Was Decedent of H	lispanic Origin? (Sp	ecify Yes or No-	United Sta	tes
(0	r iten	Fun	1 ☐ Never Married 2 ☒ Married	Armed Forces? 1 XYes 2 No Kor	ean	f Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)	Black, Wi	
93	rai', o	l by	3 Widowed 4 Divorced	If Yes, Give Year or Dates: Con	flict	1□Yes 2XINo	Specify:		Specify:	hite
5-0	72 h	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Give	dent's Usual Occup kind of work done	during most of work	ing	16b. Kind of Busines	s/Industry
121	within	mp	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired			T - 1 1	2
2	Hygie ther ther	ပိ	12 17. Father's Name (First, Middle, Last	·)	ETE	ctrical I		e (First, Middle,	Maiden Sumame)	Government
an	d be ental ked o	To Be	Paul Hoke DeLaw				Eleanor			
Maryland 21215-0036	shound M	-	19a. Informant's Name/Relationship		19b. Mailir	ng Address (Street			r, City or Town, State	Zip Code)
	and 2 alth a 27 is		Denise A. DeLawt	er/Daughter	100 I	Deep Trai	1 Lane, R	ockvill.	e, Marylan	d 20850
ore	of He of He fiterr		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [70	cemetery, crer	sition (Name of matory or other place	сө) Janua	ary 13	20c. Location - City of	or Town, State
Ĕ	Pag ment ant: i		4 ☐ Donation 5 ☐ Other (Speci	(y)	ırklawn Pa	Memorial rk	2006		Rockville	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f show eny injury or other traumatic event, I're M. dicel Examiliar in and the mailified at Once.		21. Signature of Fun ral Service Lice	MOO. MOO	0803 R	Name and Address ockville ockville	ss of Facility Rol , Inc. 30 , Maryland	ert A. 00 West 1 20850	Pumphrey 1 Montgomer: 0-2805	Funeral Home/ y Avenue
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused the dea one cause on each line.	ith. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Pneumonia	a					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse						6 25 1
	A State	16	Sequentially list conditions, if any, leading to immediate	b. Metastati		Cancer				6 Months
7	nted I Insit	min	Cause (Disease or injury		4					
í C	exection and ial-tra	Examiner	that initiated events resulting in death) Last	c Due to (or as a conse	quence of):					
8760,	death certificate be executed e attending physicien and of for use es the burial-transit	Physician/Medical	•	d						
ဖ	ertifica ding pl	Med	IF FEMALE:	220 16 100 0140000 06 0000						
Вох	eath certif attending for use ea	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of	al death 3	Ectopic pregnancy Other (specify)	y		23d. Date of d Month	elivery Day Year
o.		ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	doa 50	_ Cirior (spaciny)				
<u>a</u>	requires that the een signed by th nould be detache	by Pt	Part II. Other significant conditions	contributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
rds	w require been sig should b	ed t	Congestive Hea	rt Failure				1 □ Y	es 2∭ No 3□	Probably 4 DUnknown
of Vital Records,	aw Is b	Completed						24a. Was autop		autopsy findings available o completion of cause of
Ě	ate pag	Com						perfor	med? death	
/ita	Physician: Th this cartificate ral director, pag	Be	25. Was case referred to medical examiner?	U			26. Place of Deat			
of	2 40 7	٦.	1 Yes 2 No 27. Manner of Death		ER/Outpatier				ence 6 Other (Sp ow injury occurred	pecify)
on	ding After funa	tlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	Wor	rk? Yes 2 □ No	204. 0 6301106 11	ow anjuly occurred	
Division	or Attending after death. Director: Afte in by the funa	fica	3 Suicide 6 Could not t	28e. Place of Injury - At	nome, farm, str			281. Location (S	treet and Number or	Rural Route Number,
á	s after s after st Dire	Certification:	4 Homicide	building, etc. (Spec	ity)			City or Tow	n, State)	
	To the Hospital or At within 24 hours after of To the Funers! Direct completely filled in by	edical (29a. Certifier (Check only 2 Medical Exa	hysician: To the best of my kr miner: On the basis of examin	owledge, deat	h occurred at the tir	me, date and place,	and due to the d	cause(s) and manner	as stated.
	To the H within 24 To the F complete	Medi	one)	and manner stated.		200- 1:	o oumbor		IOd Data size of 714	oth Day Vari
	To To	-	29b. Signature and title of certified	/V	(1111)	Zac. Licens	A Humber		ANI) ARU	Init, Day, rear)
	26/1	Ŋ	20 Name and address of	I PIKORO	NUCA	Prost)	4018 +		1710 - 1107	10,0006
	30+1		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type, * ///2	25 ROCK	VILLE PI	VE #2	08 ROCKI	HUE MA SORTE
4	Sta	te	31. Date filed (Month, Day, Year)	2. Registrar's Sign	nature		VIOL II	- () 11°	,	12, 2006 12, 2006
et.	Registr	ar	JAN 1 3 200	16 January A	. Aga	W				

		,1	Chata of Manyland / Danamer
	For		State of Maryland / Departme
_	State Registrar		Certific
'	Hogistrar		

			Registrar					runcau	9 01 1	Jeaur		Reg. No	0.			
	Physici /Medio		1. Decedent's Name (I	First, Middle, Las	COLINE	Edward SR.	Ensor,	Sr.			2. Date of Month JANUA		ay 2	Year 006	3. Time of Deat	
	Examir		4a. Facility Name (If no	ot institution, give	street and numi	ber)		4b. City,	Town, or	Location of Deat	h	40	c. Count	y of Death		
			MARINER HE	ALTH CAP	RE OF GR	EATER	LAUREI	L	AURE	L		F	PRIN	CE GE	ORGE'S	
	Funeral Director	0 = -	5. Social Security Num 218-09-12	03	9x 7	7. Age <i>(In yrs.</i> 89	last birthday Yrs.	/) If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	(Month	Birth Day, Year 10, 1	916	Cou	place (State or Fore intry) yland	aigi
	pc ,		Usual Residence of De			100 0	ty, Town or I								40 d Janida Cita Lia	- '4 -
	ahov	_	10a. State	0b. County		100. 01	iy, TOWITOTI	Location							10d. Inside City Lin	
	r 28e-f show	cto	MD	Prince (George	La	urel								. Mies ⊆	140
	or 28	ire	10e. Street and Number	er				10f. Zip	Code			10g. C	itizen of	What Cou	intry?	
	23a	ai	207 9th S	treet				20	707			U.S	5.A.			
	be filed within 72 hours after death with the Maryland nia! Hygiene. ed other than "natural", or items 23a or 28e-f show event, the Madical Examinar must be notified at	Funeral Director	11. Marital Status		12. Was Deced	dent Ever in U	.S. 13	. Was Deced	ent of H	ispanic Origin? (S In, Mexican, Puer	pecify Yes o	r No-			ican Indian,	
9	after or fte	Ŀ	1 Never Married	2 Married	1 X Yes 2	2 🗆 No					o moun, oto.	<i>'</i>		ick, White	, etc.	
21215-0036	eli, c	by	3 Widowed 4 [□Divorced	If Yes, Give Year or Dat	tes:1945-	-47	1 🗌 Yes	SM NO	Specify:			Speci	<i>™</i> Whi	te	
9	2 ho	Completed		5. Decedent's Ed			16a. Dec	edent's Usua	I Occup	ation	dina	16b. l	Kind of E	Business/la	ndustry	
7	nin 7	pie	Elementary/Second	only highest gra	College (1-	4or 5+)	life.	DO NOT u	e retired	during most of world)	King					
2	i de la la la la la la la la la la la la la	0	7	, (5.12)		,	Dryv	vall m	echa	nic		Co	nst:	ructi	.on	
D	eth of the	Be C	17. Father's Name (Fin	rst, Middle, Last)						18. Mother's Nar	ne (First, Mid	ddle, Maide	n <i>Sum</i> a	me)		
ä	id be ental ked c	To B	Henry Ens	sor						Floren	ce Deb	us				
2	should nd Men marke umatic	-	19a. Informant's Name		Type, Print)		19b. Ma	ling Address	(Street	and Number or Ru	ural Route Nu	ımber, City	or Town	State, Zi	p Code)	_
<u>s</u>	d 2 stran		Beatrice	Ensor	spouse		207	0+h G	troo	t, Laure	1 Mar	- I and	20.	707		
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, tra Meone.		20a. Method of Dispos		Броивс	20b. F	Place of Dist	osition (Nat	ne of		Date Date				own, State	
ō	ges at of If it		1 Burial 2 X	Cremation 3		tate		ematory or o		1				, -		
Ė	tant tant		4 Donation 5			W.				ory Jan	13, 06	Ode	nto	n, Ma	ryland	_
ä	permit Depar Impor any in		21. Signature of Fune	ral Service Licen	S00			^{22.} Name ar Donal	d Addres dson	ss of Facility Funeral	Home,	P.A.				
ш	₫ O E # 0		45	>.4n		M007	70	313 Т	albo	tt Ave.	Laurel	, Mar	ylar	nd 20	707-4389	
			23a. Part1. Enter the shock, or heart f	disease, or complained. List only	olications that ca	used the deat ch line.	th. Do not e	nter the mod	e of dyin	g, such as cardia	or respirato	ry arrest,			Approximate Interval Between	
	Physician		Immediate Cause (Fir disease or condition	nal	Alzh	eimers	Disos	.50						İ	Onset and Death	i
	/Medical		resulting in death)		u	or as a consec		150								
	Examiner													1		
		e	Sequentially list condi	adiate	b. Due to (o	or as a conse	uence of									_
0	uted ansit	Examiner	cause. Enter Underly Cause (Disease or inju-	iury 1												
-	al-tra	Xa	that initiated events resulting in death) Las	st	c. Due to (o	r as a conseq	juence of):									_
9	be be															
87	phys the	음			, d											_
ox 68760,	th certificate be executed ending physician and r use as the burial-transit	Physician/Medical	IF FEMALE:		23c. If yes, outc	ome of orego:	ancv						224.5	-46 -1-1		
Bo	atten atten for u	an	23b. Was decedent print the past 12 mg		1 Live bir	th 2 Feta	al death 3							ate of delive onth	Day Year	
	the a	Sic	1 ☐ Yes 2 ☐ N 9 ☐ Unknown	No	4⊟Pregna 9⊟Unknov	int at time of c wn	168(1) 3	Other (sp	өспу)			-				
P.0	law requires that the death as been signed by the atte 2 should be detached for	Ph		ant conditions -	antida stanta da da	- th h t t				an in Dad I	220 [Vid tabassa		tábuta ta t	the cause of death?	2
Ś	igne bed	þ	Part II. Other significa		•	ath Dut Hot 195	suiting in the	andenying c	ause givi	en mant.						
p	w requir been si should	ted	Renal In	Sullicie	ency	*						I∐ Yes 2	Z IXI NO	3 LI Pro	bably 4 Unkno	WI
သွ	aw r	Completed										Was an utopsy	24b.	Were aut	opsy findings availa ompletion of cause	able
æ	The I	E										erformed? es 2 🔯 N		death?	2 No	o
a		a	25. Was case referred	d to medical						26. Place of Dea			0	1 1 163	2 140	_
Š	ding Physician: The In. Atter this certificate hat funeral director, page	00	examiner?	1	Hospital:	patient 2	EB/Outon	ent 3 DC	Oth				6 🗆 🔿	hor /C	(64)	
ō	Physic rubis	7: 70	27. Manner of Death				28b. Time		^	4 X Hullshig I		ibe how inju			'y'/	
S C	ding h. After fune	ţ		5 Pending investigation	28a. Date of (Month	, Day Year)	Injury	м	8c. Injun World	k? Yes 2 □ No			-			
Division of Vital Records,	al or Attending Physician: after death. I Director: After this certifica d in by the funeral director.	ertification:	2 Accident 3 Suicide	6 Could not be		of Injury - At h	ome farm				28f. Location	on (Street a	ind Num	ber or Ru	al Route Number,	
≥	2 # # =	irti.	4 Homicide	determined	buildin	g, etc. (Special	(y)	A.CO., IAU(UI)	, onlo			Town, Star				
	rs afte el Dir ed in	ပ									1					

To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Atter completely filled in by the funer

2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D24997

29d. Date signed (Month, Day, Year) January 12, 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Luis A. Casas, M.D. 8317 Cherry Lane, Laurel, Maryland 20707

State Registrar

Medical

31. Date filed (Month, Day, Year) JAN 1 3 2006



Physi /Med Exam

Physicia

Registrar 1. Decedent's Name (First, Middle, Las.			Certifica	ate of D	Death		F	eg. No.	116	UUJ.	5 7
ALLEN LE		<u></u>		· ·			2. Date of Dea Month	ith Day	Year	3. Time o	Death
la. Facility Name (If not institution, give			4h Ci	ty, Town, or	Location		JANUARY		2006 County of Death	7:55	A ^N
9005 Buttons Dri			40.01	iy, Towii, Oi		nton			ince Ge		
5. Social Security Number 6. Se 219-48-6241	9x 7. Age ■ 7. Age 7. Age	e (In yrs. last birt	Yrs. If Und Month	der 1 Year ns Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day APTIL I	d°,19	9. Birth	nplace (State unitry) Shingto	n, I
Usual Residence of Decedent 10a. State 10b. County		10c. City, Towr	n or Location							10d. Inside C	ity I imit
Maryland Prince Ge	enrae's			inton						1 □ Yes	1
10e. Street and Number	20130 0	1		Zip Code				10g. Citize	en of What Co	untry?	
9006 Buttons Dri	ive			20735					U.S.A	4 .	
11. Marital Status 1 □ Never Married 2 Married	12. Was Decedent Armed Forces? 1 XYes 2				spanic Ori n, Mexicar	gin? (Spec n, Puerto P	cify Yes or No- lican, etc.)		4. Race - Amer Black, White	e, etc.	
3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1969	1 ☐ Yes	2 X □ No	Specify:				Specify: Whi		
15. Decedent's Ed (Specify only highest grad		16a.	Give kind of	work done di	urina mos	t of workin	g	16b. Kin	d of Business/I	Industry	
Elementary/Secondary (0-12)	College (1-4or 5	5+)	Sheet	t Meta		ch.		Con	structi	ion	
17. Father's Name (First, Middle, Last)	E						(First, Middle,				
George Morris 19a. Informant's Name/Relationship (7		105	Mailine Adde	/Stroot -			Edna A			Sin Condo)	
Linda Ennis (Wit		190	9006 Bu	ass (Street a 1ttons	Dri	re C1	Route Numbe inton,	Mary	1and 20	0735	
20a. Method of Disposition		20b. Place of	f Disposition (fi	Name of or other place	9)	Jan	atel2,	20c. Loc	ation - City or	Town, State	
tX☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify			rrection	on Cem	eter	, 20		Clin	iton, Ma	aryland	
21. Signature of Funeral Service Licen:	1	01284	22. Name 6633	and Address	s of Facili 1exai	y Lec idria	Fonera Ferry	Road	Clinto	on, MD2	2073
23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused	the death. Do r	not enter the m	node of dying	, such as	cardiac or	respiratory ar	rest,		Approxima Interval Be	te
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence									
Cause (Disease or injury that initiated events resulting in death) Last	CDue to (or as	a consequence									
that initiated events resulting in death) Last	d23c. If yes, outcome	of pregnancy	of):	c pregnancy (specify)				23	3d. Date of deli Month	very Day	Year
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Registrar

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	Dhysini		1. Decedent's Name (First, Midd	le, Last)							2. Date of De	ath Da	y Yea		me of De	ath
	Physicia /Medic		Walter Elle								Januar	у 6,	2006	1	735	M
	Examin	er	4a. Facility Name (If not institution			1	4b. City, T			of Death			County of De			
*	Funeral		Shady Grove . 5. Social Security Number		OSPITAL Age (In yrs. Ia		Rock	Year	If Under		8. Date of Bir (Month, Da		lontgom	ery inthplace (S Country)	itate or Fo	oreign
	Director		098-26-1528	1₫M 2□F	72	Yrs.	Months	Days	Hours	Min.	Oct. 2	4, 1		ew Yo		
	pug M		Usual Residence of Decedent 10a. State 10b. Count	v	10c. City,	Town or Lo	ocation							10d. Ins	ide City L	imits
	Maryli f eho	lor		gomery		kvill								_	Yes 2[
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36	rs afte	ру F	1 Never Married 2 Ma 3 Widowed 4 Divorce	If Yes Give	□No 195. s: 195	_	1 🗆 Yes 2	X No	Specify:				Specify: T.	Thite		
21215-0036	within 72 hours after death with the Maryland ene. Then "naturel", or Iteme 23a or 28a-f ehow ha Medical Examinar must be notified at	ted t	15. Decede	nt's Education		16a. Dece	dent's Usual					16b. K	ind of Busines			
215	thin 7. e. en "n Medi	Completed	(Specify only higher Elementary/Secondary (0-12)	est grade completed) College (1-4)	or 5+)	life.	kind of work DO NOT use	done d retired)	u <i>ring m</i> os)	t of workii	ng					
7	filed wi Hygien other th	Con		4		Insur	ance I	Exec					nsuran	ce		
	ould be fill Mental H erked ott	Be	17. Father's Name (First, Middle	, Last)							(First, Middle	, Maiden	Sumame)			
Maryland	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene; and Mental Hygiene; is marked other then "raturel; or theme 23a or 28a-f show aumatic event, the Medical Examinar must be notified at	은	Olaf Elleson 19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailir	ng Address (Street a		gna E		er, City o	or Town, State	Zip Code)		
S	alth ar 27 io		Ruth Elleson/	Sister			-					-	Mary1		2085	0
Zre,	as 1 a of Hei of Hei r othe		20a. Method of Disposition 1 ☐ Burial 2 🌣 Cremation	2 Demoved from St.	Cer	ace of Dispo	sition (Name	e of ner place			ate		ocation - City		ate	
Ĕ	Page ment ant: if ury o		4 Donation 5 Other (Mon Cre	tgome: mator:	ium, I	nc.	1	12.	2006	Betl	nesda,	Mary1	and	
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked eny injury or other traumatic evonce.		21. Signature of Euneral Service	Litensee		Ro Ro	Name and CKVII CKVII	le, le,	s of Facilit Inc. Mary	300 Land	West 20850	Mont -280	hrey I gomery	Aven	l Ho ue	me/
П			23a. Part1. Enter the disease, of shock, or heart failure. Lis	r complications that cau t only one cause on eac	sed the death. h line.	. Do not ent	er the mode	of dying	g, such as	cardiac o	r respiratory a	rrest,		Interv	ximate al Betwee and Dea	an
, ,	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	ratory		re								inut	
	Examiner		rooming in dodin,		as a conseque	ence of):								1 77		
9.0		ler	Sequentially list conditions, if any, leading to immediate	b. Sepsi:	as a conseque	ence ol):								1 We	eek	
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8760,	s be executed sician and burial-transit	EX	resulting in death) Last	Due to (or	as a conseque	ence ol):										
876	icate be ex physician s the buria	dical		d				_		_				-		
<u> </u>	eath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. Il yes, outco	me of pregnan	псу							23d. Date of d	elivery		
P.O. Box	death e atter	Iclai	in the past 12 months?	4□Pregnan	n 2 ⊡ Fetalo tat time ol dea		Ectopic pred Other (spec						Month	Day	Yea	г
0	at the by the	hys	9 🗆 Unknown	9□ Unknow							-					
Division of Vital Records, F	w requires that the de been signed by the a should be detached f	þ	Part II. Dther significant condit	ions contributing to deat	h but not resul	lting in the u	nderlying cau	use give	n in Part 1.				use contribute Mo 3 □			
ecc	ne law ra nhas be ge 2 sh	Completed									24a. Was		24b. Were prior t	autopsy line	lings ava	lable e of
<u> </u>	: The cate h										1 Yes	rmed? 2∭No	death	,		
<u> </u>	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 1 Inp	-0-		-0-0	Othe			(Check only					
ō	Phys arthis aral di	5	27. Manner of Death	28a. Date of to		R/Outpatier 28b. Time o		c. Injury Work	4 🗆 190		ne 5 ∐ Resi 8d. Describe		6 □Other (Sp y occurred	ecify)		
<u>o</u>	inding fath. r: After e funer	atlo	1 Natural 5 ☐ Pendi 2 ☐ Accident invest	ing (Month, tigation	Day Year)	Injury	м		? ′es 2 🔲 i	No						
Divis	al or Attences after death	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	mined 288. Place of	Injury - At hon, etc. (Specify)	me, farm, str	eet, factory,	office		2	81. Location (City or To		d Number or i	Rural Route	Number,	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifyi (Check only one) 1 Medica	ing Physician: To the be I Examiner: On the basi and manner	s of examination	vledge, deatl on and/or in	h occurred at vestigation, i	t the time n my op	e, date an inion, dea	d place, a th occurre	nd due to the ed at the time,	cause(s) date and	and manner d place, and d	as stated. ue to the ca	use(s)	
	To t withi To tl	Σ	29b. Signature and title of certifi	er '			29c.		number	120			te signed (Mo.			
•	1.1		Mudu	W 1407)			DU	063	129		JAI	NUARY	7,2	006	
	1041		30. Name and address of person	who completed cause of				- د د	-1 0		Der d	Т.	_1		850	•
-0	Sta	te.	31. Date filed (Month, Day, Year	7) 32. Reg	istrar's Signatu		JUI ME	alc	al Ce	enter	prive	, Ko	ckville	e, Mar	y⊥ar	nd
	Registr		JAN 1 3 20	06 Secole	, A.	Spark	وع									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland Department of Health and Mental Hygiene Certificate of Death

Reg. No.

Reg. No. 1 - For State Registrar 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year Physician MILDRED 2006 V. FRANCIS 01-01-

00541

8:45

3. Time of Death

/Medical Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner fruit be notified at 90ce.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be exec

Division of Vital Records, P.O. Box 68760,

within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of

r د	SUMMY P		JURSING	HOME		BALTIN	MORE	II OI Dealii			N)	9
	5. Social Security Number	er 6. S		ge (In yrs. last b		If Under 1 Y Months D	ear If Und ays Hours	er 24 Hrs. Min.	8. Date of Bir (Month, Da	rth ay, Yea	9. Bir	thplace (State or Foreign ountry)
	Usual Residence of Deci	edent		86					14.14.	1414		NC
_ [10a. State 10b	c. County		10c. City, To		ation						10d. Inside City Limits
	MD	NA		BALTIN	MORE							1 A Yes 2 No
5	10e. Street and Number		N AVENL	16		10f. Zip Co	1220			10g. C	Citizen of What C	ountry?
L MILEI M	5113 EDMC	טם עטול	12. Was Decedent	Ever in U.S.	13. W	as Decedeni	of Hispanic	Origin? (Sp	ecify Yes or No	0-	14. Race - Ami	
3	1 Never Married	2 Married	Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give		i	Yes, specify □Yes 212	Cuban, Mexic		Rican, etc.)		Black, Whi	
2	3 ₩ Widowed 4 🗔		Year or Dates:				•			T		ACK
combiered	(Specify or	- T	ade completed)		(Give kı	nt's Usual O ind of work o O NOT use r	lone during m	ost of work	ring	16b.	Kind of Business	/Industry
5	Elementary/Secondary 12 TH GRAD	-	College (1-4or	5+)		CLER	K				RETAIL	
מפ	17. Father's Name (First,	t, Middle, Last)				18. Mo	_	e (First, Middle	, Maide	en Sumame)	
2	ODELL CAR	-					_ MA		MITH			
	19a. Informant's Name/I	Relationship (Type, Print)	\							or Town, State,	Zip Code)
	20a. Method of Dispositi	ion	IUEPFIEW.	20b. Place	of Disposi	tion (Name	NOSON or	AVE	BAL BAL	20c.	Location - City or	Town, State
	1 🗷 Burial 2 □ Cre 4 □ Donation 5 □		Removal from State (y)	ARBU		tory or othe	r place)	01-01	.06	ВА	MIMORE	MD
	21. Signature of Funeral	I Service Lice	nsee	1		Name and A	ddress of Fac		NERAL S			
	Daugh		1+		515	1 BALT	D. NATL	PIKE	BALTO	. MI	0 21229	
		lure. List only	one cause on each	ine.					or respiratory a	arrest,		Approximate Interval Between Onset and Death
	tmmediate Cause (Final disease or condition resulting in death)	"	Metastat			possit	ote tur	ıg				Onset and Death 1 week
		- 1	Due to (or a	a consequenc	e oi).							
ע	Sequentially list condition if any, leading to immed cause. Enter Underlying Cause (Disease or injury)	ons, diate	Due to (or a	s a consequenc	e of):							
Examine	Cause (Disease or injury that initiated events resulting in death) Last	y)	C	s a consequenc	o of):							
	3 ,		Due to (or a	s a consequenc	e 017.							
CIAILIMEDICAL			d									
31714	IF FEMALE: 23b. Was decedent preg		23c. If yes, outcom	of pregnancy 2 Fetal dea	th 3∏E	Ectopic pregr	nancy				23d. Date of de	*
	in the past 12 mon 1 ☐ Yes 2 🗷 No 9 ☐ Unknown			at time of death		Other (special					Month	Day Year
Fuys	Part II. Other significant	nt conditions	contributing to death	but not resulting	in the und	derlying caus	se given in Pa	rt I.	23e. Did	tobacco	use contribute t	o the cause of death?
2			•	•		, 9	3					robably 4 🕅 Unknown
Jiere									24a. Was		24b. Were a	utopsy findings available
Completed									auto perfe	ormed? 2 ⊠ N	death?	comptetion of cause of s 2 \(\sigma\) No
מ	25. Was case referred to examiner?	to medicat	Handal					ace of Deal	th (Check only			
2	1 Yes 2 No		Hospital: 1 Inpat		Outpatient Time of	3□ DOA	1	Nursing Ho	ome 5 Res		6 ☐Other (Spe	ecify)
		Pending investigation	28a. Date of In (Month, D	ay Year)	Injury	M 200.	Injury at Work?	□No	Zod. Doscribo	110 11 111	(ary coodinos	
2		Could not be	286. Place of It	njury - At home,	farm, stree	et, lactory, o	ffice		28f. Location (Tural Route Number,
ב כ							· · · · · · · · ·					
medical certification.	29a. Certifier 1 🔀 (Check only 2 🗌 one)	Certifying Pl Medical Exa	h ysician: To the bes miner: On the basis and manner s	of examination a	ge, death and/or inve	occurred at t estigation, in	the time, date my opinion, o	and place, leath occur	and due to the red at the time,	cause , date a	(s) and manner a nd place, and du	s stated. e to the cause(s)
ME	29b. Signature and title	Certifier	11			29c. L	icense numbe	or		29d. E	Date signed (Mon	th, Day, Year)
		INVL	U			0	26	29	4		1/3/2	2006
	30. Name and address of	of person who	completed cause of	death (Item 23a) (Type, P	riot)			1		11/1	

State Registrar

30. Name and address of pers 31. Date filed (Month, Day, Year)

2006

completed cause of death (Item 23a) (Type, Priot)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00542 State Registrar Amend Item #7 Per FH G 851 Gestificate of Death Reg. No. 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Yeer Physician Flemino 3:39A 2000 JAN 10 or sei /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, To vn, or Location of Death **Examiner** If Under 24 Hrs. BACTIMONE ike ong 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign
Country) 6. Sex 5. Social Security Number **Funeral** Days Hours Min Months 100M 2□F CNALYSAM 215.34-9998 Yrs. Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County or 28e-f show the Medical Examiner roust by notified at 1 Yes 2 No BALTIMORE mo HUDES Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 21082 GREEN USA or Items 23a LONG Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∰Yes 2 □ No If Yes, Give 1 Never Married 2 Married Specify: WHITE 21215-0036 1 Yes 2 No Specify: Completed by 3 Widowed 4 Divorced Year or Dates: "naturei", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) FARM AGRICULTURE ()WNER of Health and Mental Hygie fitem 27 is marked other t r other treumatic event, It 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be HARRISON -LEMING ORSEL 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) HYDES, MD 21082 1322 PLEMING-WIFE LONG GREEN MIARGARET 20b. Place of Disposition (Name of cemetery, crematory or other place) JANUARY 20c Location - City or Town, State 20a, Method of Disposition i i t Burial 2 ☐ Cremation 3 ☐ Removal from State CEMETERY permit. Page Department of Importent: If any injury or once. ARKUILLE 14,2006 • 4 □ Donation 5 □ Other (Specify) MORELAND 22. Name and Address of Facility 21. Signature of Funeral Service Licensee EVANS FUNERAL CHAPEL PARKUILLE. RD HARFORD 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Bladder Year **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner coronary Sequentially list conditions, if any, reading to initional cause. Enter Underlying Cause (Disease or injury Dua to (or as by Physiclan/Medical Examiner burial-transit be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, the as attending I IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No of Vital Records, P.O. the 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed (es 2 has certificate 1 Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 \(\triangle \) Nursing Home \(\times \) Residence 6 \(\triangle \) Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 2 To the Hospitel or Attending Phys within 24 hours after death.

To the Funerel Director: After this a completely filled in by the funeral directors. 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 153156

Registrar

DHMH 17 Rev 1/2001

State

2006 32. Redistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tab E. Simon Md 54 Scott Adam Rd Cockeys ville MD 21030

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#31, per DVR, G851, 1/13/06 The State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death Month 3. Time of Death Year **Physician** P. FRAZIER CHARLES 10:45 AM 01 21 06 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner MANOR 509 EJOPPA BADO RP If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min M 2□F 83 220 -22 - 2529 Yrs. Director 17-73-73 Maryland Usual Residence of Decedent the Marylend 10c. City. Town or Location 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or itams 23a or 28a-f show other treumatic event, the Medical Examinar must be notified at N/AMaryland Baltimore 1 XYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21218 2124 Barclay Street USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private family Domestic 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hester Johnson Alexander Frazier ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21234 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 sl nent of Health an ent: If item 27 is r 3225 Northway Drive Baltimore, Maryland Gloria Wyatt/ Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State Pleasant Rest Cemete16/06 permit. Page Department of Importent: If any injury or once. Injury or Towson, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home The 5240 Reisterstown Rd Baltimore, Md 21215 aus 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disable or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): ed by the attending physician detached for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown been signed by should be detac Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed Yes 2 No 1 🗆 Yes To the Hospitel or Attending Physicien: within 24 hours efter death.

To the Funerel Director: After this certifica completely filled in by the funeral director; I 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) 2 3□ DOA 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide To the Hospitei within 24 hours e To the Funerel L 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 3 30. Name and address of person who d cause of death (Item 23a) (Type, Print) FARMOUNI AND TOWSON MUHA MMGO 32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

Amend item#1, perMD, C851, 1/17/06 TT
Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible.
and item#1,19a, perMD, FH, C851, 1/13/06 TT
State of Maryland / Department of Health and Mental Hygiene Amend item#1,19a,per 1 - For State Registrar Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Physician 12:15 AM Lalmuanpuii Fanai 2006 anas /Medical 4c. County of Death 4a. Facility 4b. City, Town, or Location of Death Name (If not institution, give street and number) Examiner Baltimore Baltimore Hosyital N/A 7. Age (In yrs. last birthdav) If Under 1 Year | If Under 24 Hrs. 6. Sex 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 25F 213-73-2321 28 Director May 7,1977 India Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Worle Items 23a or 28a-f ehor 1√2 Yes 2 □ No Funeral Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5906 Cross Country Blvd #D 21215 India 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2√€ No If Yes, Give Year or Dates: 1 Never Married 2 The Marned ò 1 ☐ Yes 🏋 ☐ No Specify. Specify: Asian Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Years than Elementary/Secondary (0-12) Own Home Hygiene Housewife marked other Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be Health and Mental Sangmawia Fanai Nuchhawni Fanai 19a Informaci's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 Lairamtharlawmia Khowlhring5906 Cross Country Blvd Health tem 27 i Baltimore, Maryland Item 2 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 Removal from State = 5 permit. Page Department of Important: If any injury or ance: Druid Ridge Cemetery Pikesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility}Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 21. Signature of Funeral Service Licensee 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Breast Concer hknau/ **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine physicien and s the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Records, P.O. Box 68760,-resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 € No 1 🗌 Yes 201No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) & Baltimora Hospital 2401 W. Belveder Ave Dinai 31. Date filed (Month, Day, Year) 32. Agistrar's Signature State 2006 Registrar

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	Division of Vita To the Hospitel or Attending Physicien: within 24 hours after death.	To the Funerel Diractor: completely filled in by the	Medical C		Physician: To the sminer: On the b									
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				30. Name and address of person wh		se of death (Ite	m 23a) (Tuno	Print)	OFI	1		ormar (70,	7 500
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** GALLAGHER anuaru /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** St. Elizabeth Nursing Home Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 KF Months Days Hours 87 156-07-0422 Philadelphia, PA Director Dec. 17, 1918 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel". In the any injury or other treumetic event. 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County MD Baltimore 1 XYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3320 Benson Avenue 21227 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 KNo Specify: Specify: White Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Fred Smith Anne McDevitt ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5 Rolling Farm Court Catonsville, MD 21228 Joseph Gallagher / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Jan, 17, Cathedral Cemetery Philadelphia, PA '4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Funeral Service Licensee 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1501 Fast Fort Ave. Baltimore MD 21230 Approximate Interval Between Onset and Death Immediate Cause (Final & hom Congestive Heast **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Casellal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Ornan Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 Yes 2 No Day 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Algheimere 1 Yes 2 No 3 Probably 4 Nonknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Sez me 2 No 2 X No 1 Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Director: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funerel L 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Jan 19, 2006 Colman Law UIS

State Registrar DHMH 17 Rev 1/2001 GEETHA

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEETHA RAJAMD, 4367 HOUNS

ORIGINAL

MD-21227

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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 2006 7:20 P M January 7, Fedorovich Vladimir Gmurua /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Apt. 303 Baltimore Baltimore 9516 Perry Hall Blvd.. | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec. 24, 1930 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1₩ 2□F Russia 75 212-41-0858 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 Is marked other than "neturel", or Items 23a or 28e-f show treumatic event, Ite Medical Exact her mast be neithed at 1 ☐ Yes 2 X No Baltimore. Baltimore Director Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21236 u.s.A. 9516 Perry Hall Blvd., Apt. 303 Funerai filed within 72 hours after death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) I ☐ Yes 2 🕱 No f Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machine Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Engineer Manufacturer and Mental Hygie Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be (First Name Unknown) Orlova Fedor Gmurua ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1236 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is any injury or other tree 9516 Perry Hall Blvd., Apt. 303, Baltimore, MD Mrs. Mariya Gmyrya (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1/11/2006 Baltimore, Maryland Parkwood Cemetery ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Orlset and Death Immediate Cause (Final disease or condition resulting in death) molastadio Pnysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) attending physician Box 68760. by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the a Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 1 🗌 Yes 25 No or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 No Certification: To 1 Yes this s after death.
I Director: After this
of in by the funeral d 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Sur Dr. Sint 307 30 Name and address of person who completed cause of death (Item 2 11151 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

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	Funeral Director		5. Social Security No. 212-80-3	713		e (In yrs. last birtho 4 Yr		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D Aug. 8			Birthplace (S Country) rylanc	tate or Foreign
	and		Usual Residence of 10a. State	10b. County		10c. City, Town o	or Loc	ation					10d. tns	ide City Limits
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	deeth with the Maryland ime 23a or 28a-f ehow r must be notified at	I Director	10e. Street and Num 366 Blue	Goose Ro	ad			10f. Zip Code 2 1	.531		10g. C	itizen of What		
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land	uld be Menta rrked ific ev	ToB	John Man	n					Patrici	a O'Lea	ry			
B S	2 sho and I Is ma		19a. tnformant's Na	.me/Relationship (T	ype, Print)				and Number or Rui					
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Baltimor	Pages 1 nent of h ant: If Ite ury or ot				Removal from State)	cemetery,	crem	latory or other place Crematory	ce)	2/06		ocation - City		
pail	permit. Pages 1 and 2 should be Department of Health and Manta Important: If Item 27 is marked any injury or other traumatic ad <u>once.</u>		21. Signature of Fur	neral Service Licens	600	- 1	Sc		Funeral					
			23a. Part 1. Enter the shock, or hear	ne disease, or comp	lications that caused one cause on each li	the death. Do no	t ente	or the mode of dyir	Phail Rong, such as cardiac	or respiratory	Alt arrest,	, Md.	Appro	ximate al Between
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	Examiner	iner	Sequentially list cor if any, leading to in cause. Enter Under Cause (Disease or i	nditions, madiate rlying	b. Oue to (or as	a eonsequanca of)								
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O. Box 6	ath certif attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 9 Unknown	months?	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death		Ectopic pregnancy Other (specify)	/			23d. Date of Month	delivery Day	Year
as, r	w requires that the de been signed by the should be detached	þ	Part It. Other significance		entributing to death b	ut not resulting in t	he un	derlying cause giv	en in Part I.		tobacco	use contribute	e to the caus	e of death?
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vital i	in: The ificate ha or. page	ပိ	25. Was case refer	red to medical			_		OC Disease Day	1X Yes	2□ N	0 100	es 2□N	<u> </u>
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lon or	nding Phy th. r: After thi e funeral	ation; T	27. Manner of Death 1 Natural 2 Accident	n 5 ☐ Pending _investigation	28a. Date of Inju (Month, Da	y Year) 28b. Tin	ne of	28c. Injui	y at	28d. Describe			unk	I SCHINE
DIVISION	To the Hospital or Attending Physician: within 24 hours eller death. To the Funerel Director: After this certific completely illed in by the funeral director.	Certification;	3 Suicide 4 Homicide	6 A Could not be determined	28e. Place of tn	ury - At home, farm c. (Specify)	_	eet, factory, office		28f. Location City or To Friends	own, Stat	nd Number or le) 366 Blu	Rural Route 1e Goose	Number, e Road
	ne Hoepit 24 hour: ne Funere letely fille	edicai C	29a. Certifier (Check only one)	1☐ Certifying Phy 2☐ Medical Exam	vsician: To the best iner: On the basis of and manner st	f examination and/	death or inv	occurred at the tile estigation, in my o	ne, date and place, pinion, death occur	and due to the	e cause(s	s) and manner	as stated. due to the ca	use(s)
	To th withir To th comp	Me	29b. Signature and	title of certifier	,			29c. Licens	e number		29d. D	ate signed (Me	onth, Dey, Y	ear)

State Registrar

nd address of person who completed cause of death (Item 23a) (Type, Print)

O.C.M.E

111 PENN STREET, BALTIMORE, MARYLAND 21201

JAN.6, 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Shirley Gillespie-Schwartz 1:12 a M **Physician** Dove January 8, 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson Gilchrist Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Sear) 1929 9. Birthplace (State or Foreign Supply Day) 1929 FITThois 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1 M 2 XF 76 331-22-7249 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hyglene. Int: If Item 27 Is marked other then "naturel", or Iteme 23a or 28e-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🛮 No Baltimore MD Baltimore Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21212 154 Brandon Road Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No 1 Never Married 2 M Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ Year or Dates: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Education Professor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Florence Forsbero Dove Herbert 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 154 Brandon Rd., Baltimore, MD 21212 Alfred Schwartz -husband or other 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/10/06 permit. Page Department o Important: If any injury or once. Towson, MD Hilltop Serv. Corp. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licensee William G. Dau 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Congestive Heart **Physician** Years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of) Examiner physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No chwartz, 24a. Was an autopsy performed 2 NO Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funaral Director: After this certifica completely filled in by the funeral director. 26. Place of Death (Check only one) 25 Was case referred to medical Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 2 1 ☐ Yes 2 No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, Iarm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Jan, 08, 2006 D0061199 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Touson MO 21204 Black North Charles ST, 10 660 I 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006

DHMH 17 Rev 1/2001

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		1	For State Registrar	State of M	aryland / Depa <i>Ce</i>	artment of F rtificate of I			glene Regino 0 0 6	00550
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	the f	Director	10e. Street and Number	THORE	Ditti	10f. Zip Code	.		10g. Citizen of What	Country?
	3a or		39 FARMHOUSE C	OURT			21208			USA
	deatl	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S. 13.	Was Decedent of H	lispanic Origin? (Specify Yes or No-	14. Race - A Black, W	merican Indian,
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Itiam 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic event, Itie Modical Examinational Learning at	þ	1 ☐ Never Married 2 📉 Marrie 3 ☐ Widowed 4 ☐ Divorced		No KORFA	1□Yes 2∏XNo		, , , , , , , , , , , , , , , , , , , ,	Specify:	WHITE
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Baltimore,	permit. Pages Department of I Important: If ith any injury or o		21. Signature of Funeral Service I	icensee Cutt	1. 2	2. Name and Addre	ess of Facility S	OL LEVINS	SON & BROS	
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Division	i or Attendated after death	Certification:	3 Suicide 6 Could n 4 Homicide determine	ned 289. Place of II	njury - At home, farm, s etc. (Specify)	treet, factory, office		28f. Location (S City or Tov		r Rural Route Number,
	pital ours a ara! [200 Cortifier 1 VI Certifying	g Physicien: To the bes	t of my knowledge, dea	th occurred at the ti	me date and plac	e and due to the	cause(s) and manne	f as stated
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	P S P O			101.	MD	DZ	4352		JANUAR	4 10 2006
	10		30. Name and address of person	who completed cause of	death (Item 23a) (Type	, Print) Miss	CEA TO	DOK		
	10		NORTHWEST KI	OSPITAL 54	OI OLA COL	ITIT READ			115 OM,	33
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		Funeral		5. Social Security Number 6. Sex 7. 214-20-8220 1 ☑ M 2 ☐ F	Age (In yrs. last birthday) 79 Yrs.	Il Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Day, Y	(ear) 9.1	Birthplace (State or Foreign County) ary Land
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	Maryland	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than sny injury or other traumatic svant, tra Mones.	Ċ	19a. Informant's Name/Relationship (Type, Print) Leona Ferne Hladik/wife			and Number or Rural F worth Road			
	e,	Healt Healt tem 2		20a. Method of Disposition	20b. Place of Dispo	sition (Name of	Dat		c. Location - City	
	E O	Pages nent of nnt: if i		1 Burial 2 □ Cremation 3 □ Removal from St 4 □ Donation 5 □ Other (Specify)	Mountair Church (natory or other pla Christi Lemetery	an 1/12/0	06	Joppa, Mo	1.
	Baltimore,	permit. Departn Importa sny inju		21. Signature of Funeral Service Licensee	22	. Name and Addre	ess of Facility Funeral He	ome of I	Bel Air,	Inc.
		707 * 0		23a. Part1. Enter the disease, or complications that cau	-	10 W. Ma	cPhail Roa	d. Bel A	lir, Md.	
H.	1	Physician		shock, or heart failure. List only one cause on each immediate Cause (Final	th line.	12	4000	1		Interval Between Onset and Death
04		/Medical		disease or condition resulting in death) a	as a consequence of):	core 1	preservoro			2 days
17		Examiner	er	Sequentially list conditions. b. Seeve	as a consequence of):	nic Co	indiony	opathy		Yeurs
1	$\sqrt{}$	uted d ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events	as a consequence or,					6
10	60,	s be executed sician and burial-transli			as a consequence of):					
3			dicai	d						-
Howa	Вох 6	certific	√Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcomes the pregnant of th					23d. Date of	delivery
7.	Be	death ne atter	Physiclan/Medi	in the past 12 months? 1 Yes 2 No 4 Pregnar	nt at time of death 5	Ectopic pregnance Other (specify) _	у		Month	Day Year
	P.O.	hat the d by th fetach		9 Unknown Part II. Other significant conditions contributing to dea		nderhina cause an	(en in Part I	23e Did toba	cco use contribute	e to the cause of death?
	ds,	law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	d by	Tarrii. Ornor significant conditions contributing to doa	ar bactrocressaring in the di	nderlying cause giv	on in and i		1114	Probably 4 Unknown
	CO	aw red	Completed					24a. Was an autopsy	24b. Were	autopsy findings available to completion of cause of
	E R	The I	Com					performe	d? death	res 2 No
60	Vita	iclen: certific rector,	Be	25. Was case referred to medical examiner?			26. Place of Death (
85869	o	y Phys er this eral dii	n: To	27. Manner of Death 28a. Date of	patient 2 ER/Outpatier	IL 3LI DOA	4 Nursing Home	 5 Resident d. Describe how 		pecify)
00	ion	anding sath. or: Afte	atio	2 Accident investigation	Day Year) Injury		rk? Yes 2 □No			
0	Division of Vital Records,	or Atta	Certification:		f Injury - At home, farm, str , etc. <i>(Specify)</i>	eet, laclory, office	28	 Location (Stre City or Town, 		Rural Route Number,
		spitei hours neral y filled		29a. Certifier 16 Certifying Physician: To the b	est of my knowledge, deatl	n occurred at the ti	me, date and place, and	d due to the cau	se(s) and manner	as stated.
		To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director After this certificate has completely filled in by the funeral director, page 2	ledical	(Check only one) 2 Medical Examiner: On the bas	is of examination and/or in	vestigation, in my	opinion, death occurred	at the time, date	and place, and o	due to the cause(s)
		To To Com	Σ	29b. Signature and title of certifier)	29c. Licens	56607		1. Date signed (Me	
		NAX/		30. Name and address of person who completed cause	of death (Item 23a) (Type.	Deleth				
	_	July 1		JOSEPH ANGIZO # 205	, No 602	S. A7W.	SOD KOA	D BEL	LASK 1	UD 21014
		O.L.	ite	31. Date filed (Month, Day, Year) 32, Rec	jistrar's Signature					

			1 - For State Registrar	State of	Maryland	d / Depa <i>Cei</i>	artmen rtificat	t of H e of L	ealth a	and M	ental Hyg	iene _{g. No.}	006	00552
	Physici		1. Decedent's Name (First, Middle, Mary P.								2. Date of Deat Month Jan.		2006 ^{ear}	3. Time of Death 5:15 pm
	/Medio Examin		4a. Facility Name (If not institution, g						Location o			4c. (County of Death Baltimo	
	Funeral Director		174-12-4554	Sex 1 □ M 2 M F	7. Age (In yrs. Ia 86	st birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, NOV . I.	Year)	9. Birth 919 Pen	place (State or Foreign ntry) nsylvania
	Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County Md. Baltime	re		Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the 1 3e or 28e-	Funeral Director	10e. Street and Number 1101 Berry				10f. Zip	Code 211	36		10		en of What Cou	intry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 Is marked other then "neturel", or items 23e or 28e-f show early figury or other treumatic event. If a Madical Exacting rate the notified at ODGE.	þ	11. Marital Status 1 Never Married 2 Married	Armed For	Z ^r E¹No e	1	Was Deced f Yes, spec 1 □ Yes		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto l	cify Yes or No- Rican, etc.)		4. Race - Ameri Black, White Specify: Whi	etc.
Maryland 21215-0036	s within 72 ho piene. r then "netur The Madical I	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)		4or 5+)	2.46	dent's Usua kind of wor DO NDT us	Il Occupa rk done d se retired	ation luring most)	of workii	ng		d of Business/Ir	ndustry
/land	ould be filed Mental Hyg arked other	To Be C	17. Father's Name (First, Middle, La Edward 1						18. Mothe		(First, Middle, M			
, Mar	and 2 sho ealth and m 27 Is ma		19a. Informant's Name/Relationship Bernadette Camp:			r 1101	L Ber	ryma		ne,		stow	n, Md.	21136
altimore,	Pages 1 tment of H tent: If ite		20a. Method of Disposition 1 Burial 2 □ Cremation 3 '4 □ Donation 5 □ Other (Special Control of the Control	cify)	Cei		ts Cei	mete:	ry Ja	ň. 1	6, 2006	Rei		·
Ba	permit Depar Impor eny in		21. Signature of Juvera Service Lic	liarelt	2		TT90	5_Re	ister	stow	Chapel,	Owin	gs Mill	
	Pnysician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	ly one cause on ea	/z /+.	·~->		1	g, such as o	1	r respiratory arre	est,		Approximate Interval Between Onset and Death
	Examiner	'n	Sequentially list conditions,	b	or as a conseque									
, V , V	icate be executed physician and s the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause University of the International Cause University of the International Cause Custom Cause Custom Cause C	c	or as a conseque									
O. Box 687	death certif e attending id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths? 1 □ Yes 2 ☑ No 9 □ Unknown		th 2 Fetal on the strime of dea	death 3	Ectopic pri Other (sp					23	3d. Date of deliv Month	ery Day Year
rds, P	The law requires that the ste has been signed by the bage 2 should be detached.	by	Part II. Other significant conditions	contributing to dea	ath but not result	ting in the ur	nderlying ca	ause give	n in Part I.		23e. Did tob		/	he cause of death?
I Record		Completed									24a. Was ar autopsy perform 1 ☐ Yes 2	/	24b. Were auto prior to co death? 1 \(\subseteq Yes	opsy findings available impletion of cause of
on of Vital	To the Mospitel or Attending Physicien: Th within 24 hours after death. To the Funerel Director: After this certificate completely filled in by the funeral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of (Month		R/Outpatien 28b. Time of Injury	2	Bc. Injury Work	r: 4□ Nur at ?	rsing Hon	(Check only one ne 5 Resider 8d. Describe ho	nce 6		5 y)
Division	of or Attence after death Director: d in by the f	Certification;	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of	of Injury - At hong, etc. (Specify)	ne, farm, stre	M eet, factory	_	′es 2□N	-	8f. Location (Str City or Town,	eet and State)	Number or Rura	al Route Number,
	he Hospit in 24 hours he Funere pletely fille	Medical C	29a. Certifier 1 Certifying 1 Conciling 1 Certifying 2 Medical Ex	Physician: To the taminer: On the bas and manne	sis of examination	ledge, death on and/or inv	occurred a restigation,	at the tim in my op	e, date and inion, deati	d place, a h occurre	nd due to the ca	use(s) a ite and p	ind manner as s place, and due to	tated. o the cause(s)
ı	To t To 1	×	29b. Signature and title of certifier	m	· m	10	290	License 3	number	ـ- حز	29	d. Date	signed (Month,	Day, Year)
	7		1000	L. M	, ,	1/4	Print)	11,7	40)	C-	andr.	0.	Rein	far form, us
	Sta Registr		31. Date filed (Month, Day, Year) JAN 1 3		istrar's Signatu	K A	soll.	8						

			1- State of Maryland		artment of Health and rtificate of Death	-	giene	16	00553
			Decedent's Name (First, Middle, Last)			2. Date of Dea	ath		3. Time of Death
ı	Physici /Medic		Nancy Ann Huntzinger			Month 1-10-	-2006	Year	21:42P M
	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Dea	th	4c. Cour	ty of Death	
			Baltimore Washington Medical Cen	ter	Glen Burnie		Ann	e Aru	nde1
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. Ia 1 M 2 15 F 60	st birthday) Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min		y, Year)	9. Birthp Cour MD	place (State or Foreign ntry)
	pu k		Usual Residence of Decedent 10a. State 10b. County 10c. City.	Town or Lo	vantion				
	sho	5						1	0d. Inside City Limits 1 ☐ Yes 2 1 No
	the A	Director	MD Anne Arundel Mill 10e. Street and Number	ersvi	10f. Zip Code		10 011		
	with e or	چَ					10g. Citizen o		itry?
	leath	era	8391 Brookwood Road 11. Marital Status 12. Was Decedent Ever in U.S	13	21108 Was Decedent of Hispanic Origin? (\$	Specify Ves or No-	U.S.	A. ace - Americ	an Indian
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23e or 28e-1 show any injury or other traumetic event, If a Medical Examinar must be notified alonge.	by Funeral	Armed Forces? 1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes 2 ₹ ₹ ₹ ₹ ₹ ₹ ₹ ₹ ₹ ₹ ₹ ₹ ₹ ₹ ₹ ₹ ₹ ₹		If Yes, specify Cuban, Mexican, Puel 1 ☐ Yes 2 ☒No Specify:	to Rican, etc.)	BI	ack, White,	etc.
Ö	2 hor	Completed	15. Decedent's Education	16a. Dece	dent's Usual Occupation		16b. Kind of	Business/In	dustry
218	thin 7 9. 8n "n	ple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life.	kind of work done during most of wo DO NOT use retired)	rking			
	ad wil /gien ar th	Con	Ž	C	omputer Operator		Uti	lities	3
nd	d oth	Be	17. Father's Name (First, Middle, Last)		18. Mother's Na	me (First, Middle,	Maiden Suma	ime)	
yla	Meni Meni arka etic	ပို	Adolph Paul Balinsky			Ann Rem			
Maryland	2 sh and Ism raum		19a. Informant's Name/Relationship (Type, Print)	19b. Mailie	ng Address (Street and Number or R	ural Route Numbe	r, City or Tow	n, State, Zip	Code)
	is 1 and 2 is 1 health au itam 27 ls other trau		Mr. Brian A. Huntzinger / husba						
Baltimore,	ges it of H		20a. Method of Disposition 1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State 20b. Pla	netery, crei	sition (Name of natory or other place)	Date	20c. Location	- City or To	wn, State
₽	t. Pa rtmen rtent: njury					15-2006			lle, MD
Ba	permi Depa Impo any it		21. Signature of Funeral Service Licensee Wash A Vaneurs Mol	357	Name and Address of Facility S Second Ave SW;	Glen Bur	nie, M		
			23a. Part1. Agter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not ent	er the mode of dying, such as cardia	c or respiratory ar	rest,	1	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	al.	Infarction				Onset and Death
	/Medical Examiner		resulting in death) Due to 4 r as a conseque	nce of):	7,21				
В	LAGITITICI	_	Sequentially list conditions, b. Hyperte	45107	n				
V	ped tise	Examiner	if any leading to immediate cause. Enter Underlying Cause (Disease or injury	nce or):					
	xecul and	xan	that initiated events resulting in death) Last C. Due to (or as a conseque	nce of):					
68760,	ficate be executed physician and s the burial-transit	E E		,-					
687		edical	d						
P.O. Box	The law requires that the death certifule has been signed by the attending hage 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of deal 9 ☐ Unknown	eath 3	Ectopic pregnancy Other (specify)			ate of delive	ory Day Year
	res that signed b	by Pł	Part II. Other significant conditions contributing to death but not result	ng in the u	nderlying cause given in Part I.	23e. Did to	bacco use cor	ntribute to th	e cause of death?
g	w require: been sig should b					1 □ Y	es 2□No	3 ☐ Prob	ably 4 Unknown
Division of Vital Records,	The faw requite has been rage 2 should	Completed				24a. Was a autops perform	sy med?	Were autor prior to con death? 1 Yes	osy findings available inpletion of cause of
ita	ysician: The is certificate hadirector, page	BeC	25. Was case referred to medical		26. Place of Dea	1 ☐ Yes ath Check on or		1 🗆 163	2 140
}	Physic this ce al direc	ToE	examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 25 EF	NOutpatien	t 3 DOA Other: 4 Nursing H	lome 5 Reside	ence 6 🗆 Ot	her (Specify)
0 [ng Pl		27. Manner of Death 1 Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 2	Bb. Time of Injury	28c. Injury at Work?	28d. Describe he			
Sio	eath. or: A	catl	2 Accident investigation		M 1 Yes 2 No				
Σ	Hospital or Attending is 4 hours after death. Funaral Director: After tely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	e, farm, str	eet, factory, office	28f. Location (Si City or Town		ber or Rural	Route Number,
_	pital ours a aral i		29a. Certifier 1 Certifying Physicien: To the best of my knowle	oden death			- / > 1		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, to	edical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowle and manner stated.	and/or inv	restigation, in my opinion, death occu	rred at the time, d	ause(s) and m ate and place	anner as sta and due to	ited. the cause(s)
	To t To t	Σ	29b. Signature and title of certifier		29c. License number		9d. Date signe		Day, Year)
			· Curanal mo		D0060910		1/11/:	2006	
	3		30. Name and address of person who completed cause of death (Item 2	3a) (Type,	DOOGO910 TAL DRIVE, Q	ENI R	10 N	mo	
	Sta	te	31. Date filed (Month, Day, Year) JAN 13 7006 32. Possibar's Signatur	10211	of -	-sv o	TEIVIE,	110	
	Registr	100	31. Date filed (Month, Day, Year) JAN 13 2006 32. Forsillar's Signatur	A July	prof.				

			1 - State Registrar	tate of Maryla			t of Heal			jiene	06	00554
			Decedent's Name (First, Middle, Last)						2. Date of Dea Month		Year	3. Time of Death
	Physicia /Medic			Roland	Wende	11	Jackso	n, Sr	11	8 Bay	2006	7:04 a. M
	Examin		4a. Facility Name (If not institution, give stre Union Memorial Hosp				Town, or Loca	tion of Death		4c. Co	ounty of Deat NA	th
Ē	Funeral		5. Social Security Number 6. Sex 17 - 38 - 24 08 15 M	7. Age (In yi	rs. last birthday)	If Unde Months		nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day	, Year)	9. Birt	hplace (State or Foreign
Page 1	Director	}	Usual Residence of Decedent	6	4 Yrs.				1-31-	-1941		Md
	yland Now		10a. State 10b. County	10c.	City, Town or Lo			,				10d. Inside City Limits
	a-f st	ctor	Md. NA		Balt	timor	e					1X Yes 2□No
	be filed within 72 hours after death with the Maryland ital Hyglene. id other than "ratural", or itema 23e or 28e-f show event, I've Medical Examinat must be notified at	Director	10e. Street and Number 1231 E. Lanvale S	troot		10f. Zij	Code 21202)	1	10g. Citize	n of What Co USA	ountry?
	Tine 23	Funerai	11. Marital Status 12.	Was Decedent Ever in	U.S. 13.	Was Dece	dent of Hispan	ic Origin? (Sp	acify Yes or No-	14.	Race - Ame	ncan Indian,
9	hours after tural, or Iter	y Fur	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 □ Yes 2 □ No If Yes, Give		If Yes, spe	cify Cuban, Me	exican, Puerto	Rican, etc.)	Si	Black, White becify:	
ş	hours itural;	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educati	Year or Dates:			al Occupation				of Business/	Black
5 2	in 72	piet	(Specify only highest grade of	mpleted) College (1-4or 5+)	(Give		rk done during	most of work	ing	100. Killu	or pusiness/	moustry
21.	filed within 72 Hygiene. other than "nai	Completed	9th grade			Janit					.н.н.	
Maryland 21215-0036	ld be fill ental Hy ked oth	To Be	17. Father's Name (First, Middle, Last) Robert	К.	Jackson	n	18. /	Mary Mary	e (First, Middle, K		-,	Silver
ary	should be I and Mental I s marked of umatic eve	۲	19a. Informant's Name/Relationship (Type,	Print)	1	-			al Route Number			
	and 2 ealth a m 27 ls		Bertha Jackson	Wife					et, Bali			
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Ments Important: If item 27 is marked any injury or other traumatic e ones.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)		Place of Dispo cemetery, crea Mt. Z:	matory or	other place)		2-06		tion - City or sdowne	
Baltii	Departm Departm Importar any inju		21. Signature of Funeral Service Licensee		22		nd Address of I		March F enue Ba		Cast	202
*	40240		23a. Part 1. Enter the disease of complicat		eath. Do not en						MG 212	Approximate
	Physician		23a. Part1. Enter the disease of complicat shock, or heart failure. List only one of immediate Cause (Final				, ,					Interval Between Onset and Death
} 46	/Medical		disease or condition resulting in death)	Due to (or as a cons	equence of):	دلا د	dicco				-	Meyeus
9	Examiner	_	Sequentially list conditions, b	Personal a cons	re V	حادد	احد	Disect	se.			Unusun
	uted I Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	S	1881						15-5
o Ō	cate be executed physicien and the burial-transit		that initiated events c. resulting in death) Last	Due to (or as a cons	uence of):	7	2144					Choon
8760	cate be chysici the bu	dicai	d									
× e	eath certific attending p	/Me	IF FEMALE: 23c.	If yes, outcome of pred	nancy					220	d. Date of del	hyony
Box	death e atter	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Fi 4 ☐ Pregnant at time o		□Ectopic p □ Other (s				250	Month	Day Year
o.	res that the de signed by the a be detached t	Phys	9 Unknown	9□ U <i>n</i> known		~						
	The law requires that the death certificate be executed to hes been signed by the attending physicien and bage 2 should be detached for use as the burial-transit		Part II. Other significent conditions contrib	uting to death but not i	resulting in the u	inderlying	ause given in i	Part I.		baccouse es 2□1		o the cause of death? obably 4 Dunknown
Vital Records,	aw require is been sig 2 should b	Completed							24a. Was a		₩b. Were au	itopsy findings available completion of cause of
Ĕ		Com							autop: perfor 1 Yes	med? 2 No	death?	2 No
/Ita	iclan: Th certificete rector, pag	Be	25. Was case referred to medical examiner?		/			Place of Death	(Check only or	18)		
5	두 후 등	٦.	1 ☐ Yes 2 No Hos	1 Unpatient 2	28b. Time o				me 5 Resid			cify)
o	nding Ith. :: After	ation	1 Natural 5 Pending 2 Accident investigation	8a. Date of Injury (Month, Day Year,) Injury	м	28c. Injury at Work? 1 ☐ Yes		200. 20001100 11	ow inquity o	ocurrog	
Division of	I or Attendi after death. Director: A d in by the fu	Certification:	3 Suiside 6 Could not be	8e. Place of Injury - A building, etc. (Spe	t home, farm, st.	reet, factor	y, office		28f. Location (S City or Tow		Number or Ru	ural Route Number,
	pital c		29a. Certifier 1 Certifying Physici	To the heat of much								
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely illed in by the funeral director.	Medical	29a. Certifier (Check only one) Certifying Physici 2 Medical Examiner	On the basis of exam and manner stated.	ination and/or in	in occurred ivestigation	n, in my opinion	ite and place, i, death occurr	ed at the time, d	ause(s) ar late and pl	ace, and due	to the cause(s)
	To the To the Comp	Ä	29b Signature and title of certifier			29	c. License num	nber	-2	29d. Date s	signed (Monti	h, Day, Year)
•	1.		1/2		DM		Doos	9050		1/17	2 06	
	10		30. Name and address of person who comp	eted cause of death (I		Print)				(•	
	Sta	te	31. Date filed (Month, Pay, Year) 3 200	32. Registrar's Sig	gnature.	and a self	P					
1,	Registr		JAN I 3 200	A Secretary	A F	sarli.	V					

DHMH 17 Rev 1/2001

MAGNOLIA

002	.38		For State		epartment of Health and N Ce <i>rtificate of Death</i>		Z 11 11 10 1	0556
			Registrar 1. Decedent's Name (First, Middle, La		Dertificate of Death	Reg. 2. Date of Death	No.	3. Time of Death
	Physici		RONAL	\wedge	KINZER (TR.	January '	Day Year 9. 2006	6:10 P M
	/Medio Examin		4a. Facility Name (If not institution, given		4b. City, Town, or Location of Death	oandar y	4c. County of Death	0.10_1
			University Hospi	tal / Shock Trauma		у	n/a	
	Funeral		5. Social Security Number 6. 5	Sex 7. Age (In yrs. last birth	Months Dave Hours Min	8. Date of Birth (Month, Day, Ye	9. Birthp	lace (State or Foreign try)
	Director		094-58-0/8/ Usual Residence of Decedent	7 33 "	5.	MAY 11,1	472 WEST	VIRGINIA
	yland		10a. State 10b. County	10c. City, Town	or Location		1	0d. Inside City Limits
	a-f st	ş	MARYLAND HOWAR	2 COUNTY	COLUMBIA			1 ☐ Yes 2 No
	ith the	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Coun	itry?
	eth w		1034200	LLEGE SQUARE		4	USA.	
	item item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕅 No	 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	irs af	á	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2🖾 No Specify:		Specify:	DAV
21215-0036	be filed within 72 hours after deeth with the Maryland ital hygiene. Id other then "natural", or iteme 23a or 28a-f show event, the Madical Examinar must be notified at	Completed	15. Decedent's E (Specify only highest gr	ducation 16a. E	ecedent's Usual Occupation	168	o. Kind of Business/Inc	dustry
2	within 7 ene. then "r	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	Give kind of work done during most of work ife. DO NOT use retired)	ing		
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and		Be	17. Father's Name (First, Middle, Last	KINZER		e (First, Middle, Mai	den Sumame)	
Maryland	should to Ment marked matic	2	19a. Informant's Name/Relationship		Aailing Address (Street and Number or Rur.		ity or Town State Zin	Code
Σ	s 1 end 2 should F Health and Mer Item 27 ie marke other traumatic		BABETTE KINZ		342 COLLEGE SOIL			21044
re,	es 1 end of Health fitem 27 r other tr		20a. Method of Disposition	20b. Place of D	Disposition (Name of crematory or other place)	Date 200	c. Location City or To	wn, State
Ē	Peg int: i		1,⊠Burial 2 □Cremation 3 □ 4 □Donation 5 □Other (Speci	THemoval from State	EEK CHURCH CEMETER 01-1	4-06 1	ASHINGTO	1150
Baltimore,	permit. Pe Depertmen Important: eny injury		21. Signature of Funeral Service Lice		22. Name and Address of Facility BR	OWNUR	. FUNERA	L'HOME
	205 g		(wetrich	N. Williams				,21217
			shock, or heart failure. List only	plications that caused the death. Do no one cause on each line.	t enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Multiple	Gunshot Wour	rds		Criset and Death
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		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequence of);			
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Box	death certi e ettending id for use a	Iclan/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive Month	ry Day Year
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<u>α</u>	The law requires that the ste has been signed by th bage 2 should be detache	by Pt	Part II. Other significant conditions	contributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did tobac	co use contribute to th	e cause of death?
ğ	w requires to been signer should be					1 ☐ Yes	2 No 3 Prob	ably 4 Unknown
of Vital Records,	e law requ has been ge 2 shoul	Completed				24a. Was an autopsy	24b. Were autor	osy findings available
Œ.		Com				performed	i? death?	2□ No
Vita	ilcien: certific rector,	Be	25. Was case referred to medical examiner?	Manager		h (Check only one)		
of	G S X	2	1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2 ☐ R/Outp 28a. Date of Injury 28b. Tir			e 6 Other (Specify)
	Attending Ph r death. ector: After th by the funeral	tlon	1 ☐ Naturat 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Inj	ury Work?	28d. Describe how i		
Division	or Attend efter death Director: ,	Ifica	3 Suicide 6 Could not b	28e. Place of Injury - At home, farn	IC !	28f Location /Stree	t and Number or Bura	l Route Number,
ā	ital or irs efte rai Dir	Certification:	4 Homicide	building, etc. (Specify)		City or Town, S	(MOVENI)	mondson Ave
	To the Hospital or Attentwithin 24 hours effer deatl Within 24 hours affer deatl To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifying P	nysician: To the best of my knowledge,	death occurred at the time, date and place, or investigation, in my opinion, death occurr	and due to the caus	e(s) and manner as st	ated.
	To the H within 24 To the F complete	Medi	51107	and manner stated.				
	So T So	-	29b. Signature and title of certifier		29c. License number		Date signed (Month, L	
,	ì			ulan md	OCME	Jan	nuary 10, 2	.006
	0		A translate 1	completed cause of death (Item 23a) (Tenn Street, Baltimo				
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	- 1 A - 1/2 -			
	Registr		JAN 1 3	2006	forly			
DF	IMH 17 Rev 1/2	001			Control of the contro			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death Reg. No. 2, Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 4:309. M NAPP January 10 2006 JENE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner bodyington Medical Center 5. Social Security Number 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6 Sex **Funeral** Min Months Days Hours 15M 20F Yrs. 215-34-7944 MARY Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State "naturel", or Items 23a or 28a-f show Department of Health and Mental Hygiene. Important: if items 23a or 28a-f shoy important: if item 27 Is marked other than "naturel", or items 23a or 28a-f shoy eny injury or other treumatic event, the Mudical Examinal must be notified at once. 1 ☐ Yes 2 ☐ No Director ANNE Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 1604 ILEMAN RIUC Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 Who Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ENGINEER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be KATHERINE GEORGE YANGLING 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nd. GIEN KURNIE KNAPP-21061 DRIVE 1604 liEMAN 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State *4 ☐ Donation 5 ☐ Other (Specify) GEN HAVEN MEM. PACK JAN. 13, 2006 GEN BURNIE 22. Name and Address of Facility GONCE FUNERAL SERVICE, P.A. 21. Signature of Funeral Service Licensee 23a Jart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fedure. List only one cause on each line. BALTO. MD 21225 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cancer Lung Terminal /Medical Due to (or as a consequence of): **Examiner** 12neun70119 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the burial-transit Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the funeral director, page 2 autopsy performed 2 3 NO 2V No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 10 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 27. Manner of Death 28b. Time of To the Hospitel or Attending 1 Natural 5 Pending investigation death. 1 Yes 2 No s after death 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide determined 4 Homicide within 24 hours a To the Funerel C Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00055973 10,2006 Tanvaru kassehun M.D.

Registrar

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State

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20904

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

JAN 1 3 2005

way

32. Registrar's Signature

CORNEL A. LEMON 06-00241 RKD

		1	1 - For State of Maryland / State Registrer	-	artment of He		ental Hygie Reg.	711110	00558
			1. Decedent's Name (First, Middle, Last)				2. Date of Death Month		3. Time of Death
	Physicia /Medic		Cornel A.		Lemon		JANUARY	9, 2006	9:18P. м
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Lo			4c. County of Dea	th
			ST. AGNES HOSPITAL	hirthele (1)	BALTIMOR		8. Date of Birth		holace /State or Foreign
	Funeral Director		5. Social Security Number 214–17–9822 6. Sex 1 ☑ M 2 □ F 23	Yrs.		Hours Min.	(Month, Day, Ye 7–23–8:	ear) Co	thplace (State or Foreign ountry) Md.
			Usual Residence of Decedent				, 20 0		
	how		10a. State 10b. County 10c. City, To						10d. fnside City Limits Y Yes 2 □ No
	8a-f	cto	124	artı	more		100	. Citizen of What Co	
	with the	吉	10e. Street and Number 1704 Fairbrook Court		10f. Zip Code 21244	1	109.	USA	ounti y :
	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f ehow the Madical Exertainer must be notified at	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S.	13.	Was Decedent of Hisp f Yes, specify Cuban,		city Yes or No-	14. Race - Ame	
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93	rai', or	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 21 No	Specify:		Specify:	Black
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d 2	Hygi ther int.		12th grade 17. Father's Name (First, Middle, Last)		1	8. Mother's Name	(First, Middle, Ma.	iden Sumame)	
a u		To Be	Cornelius R.	Br	ooks	Sandr	a E	•	Lemon
Maryland	S D E E		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street an				
	Heelth a tem 27 li		Sandra E. Lemon Mother		4 Fairbro				21244
ore	es 1 ar of Hee if item or othe				natory or other place)	D.		c. Location · City or	_
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Baltimore,	permit. Pages. Depertment of It importent: If ite eny injury or of once.		21. Signature of Funeral Service Licensee		Name and Address March F.H	. East	1101 E.	Baltimore North A	
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	Physician	4	Immediate Cause (Final disease or condition	oou	nds Cleon	ract)	6 Chi	st	Chiset and Bount
	/Medical Examiner		resulting in death) Due to (a) as a consequence	ce of):					
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89	The law requires thet the death certificate be executed sie has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Med	IF FEMALE:						
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Ţ	iding Physician: th. : After this certifice funeral director, p	To B	examiner? 1X Yes 2 No Hospital: 1 npatient 2X ER	Outpatie	nt 3 DOA Other	4 🗀 Nursing (10)		ce 6 □Other (Sp.	ecify)
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Division	or Att	Certification:	4 Homicide determined building, etc. (Specify)		reel, factory, office		City or Town,	State) 163 S	maraters
	pitei ours e eral [2	29a. Certifier 1 Certifying Physician: To the best of my knowle	- Neger Street	th occurred at the time	e date and place.	and due to the cau	se(s) and manner a	is stated.
	24 ho 24 ho Fun etely	edical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	and/or in	nvestigation, in my opi	inion, death occurr	ed at the time, date	e and place, and du	e to the cause(s)
	To the Hospitel or Attent within 24 hours effer death To the Funeral Director: completely filled in by the	Me	29b. Signature and title of cellifie		29c. License	number	290	I. Date signed (Mor	nth, Day, Year)
			MANA IVI		0.C.1	M.E.	JA	NUARY 10,	2006
-	·^1		30. Name and address of person who completed cause of death (ftem 23	Ba) (Type	, Print)	CIDDITION TO	AT IDTN6007	MADS/T AN	D 21201
	<u></u>		S.K. HOGAT		TII PENN	STREET B	ALTIMORE	, MARYLAN	D 71701
	St. Regist	ate	31. Date filed (Month, Day, Year) JAN 1 3 2006 32. Registrar's Signature	9	well				
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			For State Registrar	State of Marylan		artment of <i>tificate of</i>		nd Men		ene) ()	6 (0559
	45. 1		1. Decedent's Name (First, Middle, Last)					Date of Death Month	Day	Year	3. Time of Death
*	Physici /Medio		JOLINDA LEE	LEBENTRITT					anuary			7:14 a ^M
	Examin		4a. Facility Name (If not institution, give			4b. City, Town,	_	Death		4c. County		
100		§.	Laurel Regional H		last hirthday	Laure.		4 Hrs. 9 r	Date of Birth	Prin		eorge 's place (State or Foreign
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3	Director		Usual Residence of Decedent	n 32				ρα		1733	Ital	1545
	show		10a. State 10b. County	10c. Cit	y, Town or Lo	cation					1	10d. Inside City Limits
	B Ma	ctor	Maryland Prince	George's La	urel							1 ☐ Yes 2 ☐ No XX
	or 28	Director	10e. Street and Number	_		10f. Zip Code			10	g. Citizen of		ntry?
	ath w		10304 Snowden Road		6 40	2070		in 2 /Conneitu	Vog or No	U.S.A		can Indian,
	within 72 hours after death with the Maryland ene. than "natural", or itams 23e or 28e-f show ha Madisal Evaminar must be notified at	Funeral	11. Marital Status 1 ☐ Never Married 2XXMarried	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 🕅 Xo	.5. 13.	Was Decedent of If Yes, specify Cu	ban, Mexican,	Puerto Rica	in, etc.)		ck, White,	
21215-0036	irs aff	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2XX	Specify:			Specif	y:Whit	e
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215	thin 7	pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work don DO NOT use retir	ed)	or working				
21	ed wi	S		2 Years	Le	gal Sec		1- N /F	rst. Middle, M	Legal		
pu	tal H d oth	Be	17. Father's Name (First, Middle, Last) Joseph Lee Eaton						.,	aiden Sumar	ne)	
Maryland	d Mer narke	은	19a. Informant's Name/Relationship (7	una Briatt	10h Maili	na Address (Stree	Barba.			City or Town	State 7ii	Code)
Mai	d 2 st		Edward Lebentritt			4 Snowde			rel, Ma	0.05		
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mantal Hyglene. Important: if item 27 is marked other than "natural; or items 23e or 28e-f show amy injury or other traumatic event, the Madical Examinational Department of the Land Andrea.	b	21. Signature of Funeral Service Licen			Name and Add Donalds					OII F.	aryrand
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	ate be executed / Medical Examiner and ithe burial-transit ithe burial-transit ithe burial-transit ithe burial-transit ithe burial-transit ithe burial-transit ithe burial-transit ithe burial-transit ithe burial-transit it	Examiner	23a. Part 1. Enter the disease or come shock, or heart failure. Ust only disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Coronary Ar Due to (or as a consect Chronic Lin Due to (or as a consect Atheroscler Due to (or as a consect Due to (or as a consect C. Due to (or as a consect Due to (or as a consect Due to (or as a consect	tery Duence of): g Dise	isease						Interval Between Onset and Death
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Ω.	res that the dei signed by the a be detached f	Ph	Part II. Other significant conditions of	ontributing to death but not res	sulting in the u	inderlying cause	given in Part I.		23e. Did tob	acco use con	tribute to	the cause of death?
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f V	Physician: this certific ral director,	To B	examiner? 1 Tes 2 No	Hospital: 1 ☐ Inpatient 2🏋	ER/Outpatie	nt 3□DOA	Other: 4 🗆 Nur	rsing Home	5 🗌 Residei	nce 6 🗆 Ot	her (Speci	fy)
0 1	tding Physician: th. : After this certific funeral director,	Ë	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	V			Describe hor	w injury occu	rred	
Division of Vital Records,	To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ome, farm, si		□Yes 2□N 		Location (Str City or Town		ber or Rui	al Route Number,
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	To th Withir To th comp	Me	29b. Signature and title of certifier	1.00	9	29c. Lice	ense number		29	d. Date sign	ed (Month	, Day, Year)
)	12		30. Name and address of person	mplet cause of death (Ite	m 23a) (Type		9220		- 11	Januar	cy 9,	2006
	1		Neil A. Meade, M				urel, M	Maryla	and 20	708		
	St Regist	ate rar	31. Date filed (Month, Day, Year) JAN 1 3 20	329Registrar's Sign		esti s						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** January 8, 2006 20:39 Nan M. Lane /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Harford Memorial Hospital Havre de Grace If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🕱 F 1908 North Carolina Director 214-24-5103 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State traumatic event, the Medical Exeminar must be notified at 1 ☐ Yes 2 XNo Directo Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 21001 Items 23a USA 9 Post Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ♣ No
If Yes, Give Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 ö 1 ☐ Yes 2 No Specify: Specify þ 3 X Widowed 4 □ Divorced Year or Dates "neturel', White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry marked other then Elementary/Secondary (0-12) College (1-4or 5+) Foster Care 8 Care Giver 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be h and Mental I ပ Martha Frances Gambill William Franklin Blevins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 137 Goucher Way, Churchville, Maryland 21028 of Health Linda Glassman / Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ō 1 Daurial 2 Cremation 3 Removal from State ŏ Department of Important: If eny injury or other ' 4 ☐ Donation 5 ☐ Other (Specify) Highview Memorial Grdns. 1-12-06 Fallston, Maryland 21. Signature Anneral Service Licensee McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** S- uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Exami Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Y*e*ar Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🗌 Yes 20 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 24a. Was an certificate has autopsy performed 2 100 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

Division of Vital Records. Certification: Director: in by within 24 hours a To the Funerel [1 entifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of grath (Item 23a) (Type, Print) V AZATIN 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 1 3 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiepe 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 3:04 PM **Physician** Lauran 10 2006 /Medical 4c. County of Death or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner altruore Hospital 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2□ F 66657 MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Baltimore Gity 1 Yes 2 No atr Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Broadwa INSA al 213 death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, . Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 Yes 2 10 If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 9 Specify: Black 1 ☐ Yes 2 ☐ 10 Specify. ģ 3 ☐ Widowed 4 ☑ Divorced "natural", Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be illed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 10TH DISABLE N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be BEVERLY BRANCH LEROY LANGLEY, SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2 Broadwan momes 20b. Place of Disposition (Name of cemetery, crematory or other place) Bevery Languers BALTIMORE, MD. 21213 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 17,2006 Balto,MD. 4 ☐ Ponation 5 ☐ Other (Specify) KING MEMORIAL PARK /JAN. ress of Facility

B. SCRUGGS FUNERAL HOME nature of Funeral Service Licensee Approximate
Interval Between
Ons, and Death PRESTON ST. BALTO, MD. 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2□ No 1 Yes 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 Tyes 1_Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Injury at Work? 1 ☑Natural 2 ☐ Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined within 24 hours after dea To the Funeral Director completely filled in by th 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 😂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier on who completed cause of death (Item 23a) (Type, Print).
HOLAN, MD 301 ST Paul ST. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

			For	State of Maryland	-			Mental Hyg	giene		
			State Registrar		Certi	ficate of D	Peath		Reg. No.	5	00563
я	Physici	an	1. Decedent's Name (First, Middle, Las.		10 -			2. Date of Dea	Day Y	'ear	3. Time of Death
	/Media	al .	4a. Facility Name (If not institution, give	E LAZA		4b. City, Town, or I	Location of Doct	THURAS	4c. County of		The
1	Examin	ier		SAITAL CO	272	Park I	A LICTA	201	BA1	To de	6.2
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birtl	h Voarl	Birthpla Countr	ce (State or Foreign
	Director		218-03-0324	^{□M 2} X F 85	Yrs.	Months Days	Hours Min.	MAY 10,	1920	Country	" MD
	pug M		Usual Residence of Decedent 10a. State 10b. County	10c. City.	Town or Loca	tion				100	d. Inside City Limits
	Marylé 1 sho	5		IMORE			BALTIMO)RF			1 ☐ Yes 2 ☑ No
	r 28e	Director	10e. Street and Number	THORE		10f. Zip Code	DALLITA		10g. Citizen of Wh	at Countr	y?
	ath with the Marylan 23a or 28e-1 show	al D	3651 FOREST HILL	ROAD			21207				USA
	ems (Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	. 13. Wa	as Decedent of His 'es, specify Cuban	spanic Origin? (9 n, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Black,	America White, et	
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates:]Yes 2∭∏No	Specify:		Specify:		WHITE
21215-0036	72 hours after death with the Maryland Insture!; or Items 23a or 28e-f show disul Exert and be notified at		15. Decedent's Ed		16a. Decede	nt's Usual Occupat	tion		16b. Kind of Busi	ness/Indu	stry
212	C * 24	piet	(Specify only highest grad	de completed) College (1-4or 5+)	(Give ki	nd of work done du NOT use retired)	urina most of wo	orking			
21	filed wit Hygiene other the	Completed	Elementary/Secondary (0-12)		HOMEM				OWN HOM	E	
nd	d ta b y	Be	17. Father's Name (First, Middle, Last)		MAASS		18. Mother's Na BESSI	me (First, Middle,		OTTE	NHEIMER
Z Z	∠ ≥ m m	2	ALVIN 19a. Informant's Name/Relationship (7)	ivne Print)		Address (Street at			r, City or Town, St		
Maryland	12 7 is			SON					BIA, MD		
ē,	s 1 and f Health Item 27 other to		20a. Method of Disposition	20b. Pla	ce of Disposit			Date	20c. Location - Ci		
E L	Pages nent of ent: If It ary or o		1 X Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ 9ther (Specify	Removal from State	-	CEMETERY	.	12/2006	BALTIM	ORE,	MD
Baltimore,	permit. Pag Department Importent: I eny injury o		21. Signature of Fundal Service Lice	see /		Name and Address			ON & BRO		
	70 E 9 9								IKESVILL		D 21208
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final	at a			4.		/	. 1	Approximate nterval Between Onset and Death
	Physician /Medical		disease or condition resulting in death	a. Due to (or as a conseque	TE A	40CAS	2D146	(NFA)	CTION		
н	Examiner				51100 017.						
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8760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit		loosing in goalin, said	Due to (or as a conseque	ence on.						
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	death	icia	in the past 12 months? 1 □ Yes 2 ☑ No	1 Live birth 2 Fetal of 4 Pregnant at time of dea 9 Unknown		ctopic pregnancy Other <i>(specify)</i>			Month	n D	Day Year
P.O	that the de led by the a detached	Phys	9 Unknown					- OO- Dida			
	res thai signed I I be det	by	Part II. Other significant conditions of	ontributing to death but not result	ting in the und	20-	r		bacco use contrib es 2 No 3		bly 4 Unknown
orc	v requir been s should	eted	Direct 2	ACAT COLLEGE			ve pul	a None			
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Vital		e Co	25. Was case referred to medical	DENT : DET	uen 7	4	26 Place of De	ath (Check only o		Yes 2	DING .
N.	Physicien: this certificantal director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Depatient 2 E	R/Outpatient	Othe	r		lence 6 Other	(Specify)	
Jo L	ding Ph		27. Manner of Death 1 (12) Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at ?	28d. Describe h	ow injury occurred	1	
Sio	Attending or death. ector: After by the fune	catic	2 Accident investigation 3 Suicide 6 Could not be				es 2 □No	2011			
Division	or Attence after death Director: in by the	Certification:	4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)		t, factory, office		City or Tow	Street and Number m, State)	or Hurai	Houte Number,
J	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying Ph	ysicien: To the best of my know	rledge, death of	occurred at the time	e, date and plac	e, and due to the	cause(s) and mann	ner as sta	ted.
	n 24 h	edical		iner: On the basis of examination and manner stated.	on and/or inve	stigation, in my op	inion, death occ	urred at the time, o	date and place, an	d due to t	he cause(s)
	To the To the comp	W	29b. Signature and title of certifier	un A		29c. License			29d. Date signed (Month, D	ay, Year)
) JA	350 mg)	019	502	V	ANUAR	49,	2006
	13		30. Name and address of person who	completed cause of death (Item	23a) (Type, P	rint)	Nont	WEST !	Hospith	< (exten
) 	ate	31. Date filed (Month, Day, Year)	Registrar's Signatu	ure 🧳	•0 •	KANDA	11570W	w, near	yLAN	D 21133
	Regist		JAN 1 3 200	6 Desus S.	GORA	a)					

		•	For State Registrar	State of Ma		partment of ertificate of	f Health and I of Death		jiene 006	00564				
ó	# Ja		Decedent's Name (First, Middle, Last	')				2. Date of Dea Month	th	3. Time of Death				
	Physicia /Medic		JOHN JOS	EPH LYONS				JAN 5	Day Ye 2006	3:48 A M				
	Examin		4a. Facility Name (If not institution, give			4b. City, Town	n, or Location of Death	ר	4c. County of E	eath				
7. 4.			NATIONAL NAVA				BETHESDA			TGOMERY				
T	Funeral		5. Social Security Number 6. Se	X 7. Age M 2□ F	(In yrs. last birthd	Months Da		8. Date of Birth (Month, Day	Year) 9.	Birthplace (State or Foreign Country)				
- A) :	Director		173.05.6445 /		86			June 3,	1919	Pennsylvania				
	land ow		10a. State 10b. County		10c. City, Town o	r Location				10d. fnside City Limits				
	Mary feh	ţō	Maryland Mont	gomery			Silver Spring			1 ☐ Yes 2 No				
	r 28a	Director	10e. Street and Number	gomory	·	10f. Zip Cod		1	l 0g. Citizen of Wha	Country?				
	h with		1500 Ednor Rd.				20905	:		U.S.A.				
	within 72 hours after death with the Maryland ene. than "natural", or Iteme 23e or 28a-f ehow the Medical Examiner must be notified at	1500 Ednor Rd. 11. Marital Status 12. Was Decedent Ever in U.S. Amyled Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, e						pecify Yes or No-		American Indian, Vhite, etc.				
9	after or Ito	F	1 Never Married 2 Married	1 X Yes 2 ☐ N If Yes, Give	1958	1 □ Yes 2 🗶			Specify:					
ğ	ural',	d b	3 Widowed 4 □ Divorced	Year or Dates:	1967	- ' '				White				
21215-0036	"nate	3 Widowed 4 Divorced Pear or Dates: 1967 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Naval Officer						16b. Kind of Busine						
12	withir ane. than	Elementary/Secondary (0-12) College (1-4or 5+) Naval Officer							Ca	eer Military				
0 0	Hygid Hygid Sther	S	17. Father's Name (First, Middle, Last)					ne (First, Middle,	Maiden Surname)					
au	ld be ental ked c	To Be	Josep	h Lvons				An	ne unknown					
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 ie merked other then "natural", or Iteme 23a or 28a-f ehow any injury or other treumatic event, the Madical Examiner must be notified at once.	-	19a. Informant's Name/Relationship (T		19b. M	ailing Address (Str	eet and Number or Ru			e, Zip Code)				
	alth a alth a 27 le		Ms. Mary S. Lyons	Daugh	ter	246 Deakyr	neville Road To	wnsend, DE	19734					
j.	of He Item		20a. Method of Disposition		20b. Place of Di	sposition (Name or crematory or other	place)	Date	20c. Location - City	or Town, State				
Ĕ	Page nent o		1 Buria 2 □ Cremation 3 □ I 4 □ Donation 5 □ Other (Specify			Louis Ceme	0.1	1/10/2006	006 Clarksville, Maryland					
altimore,	Departr Departr Importe any inju		21 Signature of Puneral Service Licen	9	. 7	22. Name and Ad	Idress of Facility							
m	80 5 8 8	1	Malustiller	il Mi	10535	Slac	k Funeral Hom	e, P.A.	City MD 210	143				
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and De											
200	Physician		Immediate Cause (Final disease or condition	ACUT	TE MYOCAR	DIAL INFA	ARCTION			Onset and Death				
, i	/Medical Examiner		esulting in death)	Due to (or as	a consequence of):									
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X	Attending Physicien: The law requires that the death certific reasth. r death. ector: After this certificete has been signed by the ettending by the funeral director, page 2 should be detached for use as	Z.	IF FEMALE: 23b. Was decedent pregnant	23c. ff yes, outcome		۵۵۶۰۰۰			23d. Date of	delivery				
Division of Vital Records, P.O. Box	death e ette d for	by Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at	2 Fetal death time of death	3 ☐ Ectopic pregna 5 ☐ Other (specify			Month	Day Year				
Ö	ut the by th tache	hys	9 Unknown	9□ Unknown										
S,	as tha gned se de	by P	Part II. Dther significant conditions co	entributing to death be	ut not resulting in th	e underlying cause	given in Part I.	23e. Did to	bacco use contribu	e to the cause of death?				
ord	w require been si should b	be						1 🗆 Y	es 2. XNo 3.	Probably 4 Unknown				
ပို	law r as be 2 sh	Completed						24a. Was a autop:	sy prior	autopsy findings available to completion of cause of				
<u> </u>	The bete h page	Con						perfor		h? Yes 2□ No				
ita	cian: ertific	Be	25. Was case referred to medical examiner?	11				ath (Check only or						
<u>}</u>	Physi this c	မ	TIL TES 2X NO		nt 2 ER/Outpa	atient 3 DOA	Other: 4 Nursing H			Specify)				
Z	ling F	lo lo	27 Manner of Death 1 Matural 5 ☐ Pending	28a. Date of Inju (Month, Da)			njury at Work? 1 □ Yes 2 □ No	28d. Describe h	ow infury occurred					
S	death death stor: the	cat	2 Accident Investigation 3 Suicide 6 Could not be	29a Place of Ini	ury - At home, farm			28f Location (S	treet and Number o	r Rural Route Number,				
<u>></u>	lor A after Direct In by	Certification:	4 Homicide determined	building, et	. (Specify)	, street, ractory, on		City or Tow		, , , , , , , , , , , , , , , , , , , ,				
_	spita lours neral filled		29a. Certifier 1X Certifying Phy	sician: To the best	of my knowledge, d	eath occurred at th	e time, date and place	! e, and due to the c	ause(s) and manne	r as stated.				
	HO 24 h Fui	Medical			examination and/o		ny opinion, death occu							
	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Me	29b. Signature and title of certifier			29c. Lic	ense number	Z	29d. Date signed (N	lonth, Day, Year)				
	ار		1/1/	a A	MD	010	01236858 (1	VA)	JAN 5 2	006				
	14		30. Name and address of person who d	completed cause of d	eath (Item 23a) (Ty		NATIONAL 1							
	10		COREY A. CARTER	LT MC US	SN		BETHESDA 1							
n. 3	Sta		31. Date filed (Month, Day, Year)	64	ar's Signature	6			·					
*	Registrar JAN 1 3 2006													

		-	For State Registrar	State	of Marylar		artment of tificate			ind M	_	giene Reg. Nõ		6	00565
	ysicia		Decedent's Name (First, Middle, Last Brunhild		М	cBride					2. Date of De Month Januar	Da		Year	3. Time of Death 7:45am M
	/ledic amin	_	4a. Facility Name (If not institution, give		number) 4b. City, Town, or Location of Death Ellicott City				4c. County of Death Howard						
Fun Dire			123-10-0031	x □M 2 M F	7. Age (In yrs. 7 9	last birthday) Yrs.	If Under 1 Ye Months Day	ar	If Under 2 Hours		8. Date of Bir (Month, Da Nov.6,19	th i <i>y, Year)</i> 926		Coul	place (State or Foreign ntry) nican Republi
Maryland -f ehow	fied at	tor	Usual Residence of Decedent 10a. State 10b. County MD Howaii	-d	10c. Ci	ty, Town or Lo	cation	Ci	ty						10d. Inside City Limits
with the	the roll	Funeral Director	10e. Street and Number 4659 Pinto Court	;			10f. Zip Cod 214					-	izen of WI	nat Cour	ntry?
ore, Maryland 21215-0036 stand 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23s or 28s-f ehow	Startaline cou	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed F	2 X No ive	1	Vas Decedent of Yes, specify C	uban,	anic Orig Mexican Specify:	in? (Spe Puerto	ecify Yes or No Rican, etc.))-		White,	can Indian, etc. ite
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land 2 lid be filed lental Hygi ked other	Ic event,	To Be Co	17. Father's Name (First, Middle, Last) Juan Lopez						8. Mothe		(First, Middle,		Sumame)	
Mary and 2 should be alth and Mark 27 is mar	r traumat		19a. Informant's Name/Relationship (er		g Address (Stre					-			Code)
Baltimore, permit. Pages 1 ar Department of Hea	ury or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from	State	cemetery, cren	sition (Name of natory or other p Cemete:	olace)	1	118) 06		kin,	•	own, State
Balt permit. Depart	any inj		21. Signature of Funeral Service Licen	S00		22		L_{\bullet}	Steve	ns F	uneral Hr altimore				
Physic /Med			23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on	caused the deal each line. d stage (or as a consecutive)				such as o	cardiac o	or respiratory a	rrest,			Approximate Interval Between Onset and Death
Exami		iner	Sequentially list conditions, if any, leading to minediate cause. Enter Underlying Cause (Disease or injury	Due to	cheal c	uanea of):									
. Box 68760, death certificate be executed extending physician and	the burial-tran	dicai Examiner	Causa (Disease of Highly that infiated events resulting in death) Last	Due to	ver cirr (or as a consec Mestive	uence of):	t faile	سر							
Box 6 death certified attending	detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 MeNo 9 Unknown	1 Live	utcome of pregni birth 2 Feta nant at time of co	ıl death 3 □	Ectopic pregna Other (specify)						23d. Date Monti		ery Day Year
ords, P.O requires that the een signed by th	peq	þ	Part II. Other significant conditions c	ontributing to	death but not res	sulting in the ur	nderlying cause	given	in Part I.		T	obacco u Yes 2			ne cause of death?
I Rec The law ate has b	page 2 should	Completed									24a. Was autor perfo 1 Yes		pri de	or to co ath?	psy findings available mpletion of cause of 2 No
of Vital F Physician: Th this certificate		To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	Inpatient 2	ER/Outpatien	t 3 DOA	2 Other:	110000		ne 5 Lesion		S ∏Other	(Specifi	u)
ding After	funeral		27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	28a. Date (Mor	of Injury oth, Day Year)	28b. Time of Injury	28c. Ir	Vork?		- 2	28d. Describe I				,,
Division ital or Attend its after death at Director:	completely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Plac	e of Injury - At h ling, etc. (Speci	ome, farm, stre fy)	eet, factory, offic	ce		2	28f. Location (5 City or Tox	Street an wn, State	d Number }	or Rura	l Route Number,
e Hospital 24 hours a	letely fill	edical	29a. Certifier (Check only one) Certifying Ph	iner: On the l	e best of my kno casis of examina oner stated.	owledge, death ation and/or inv	occurred at the restigation, in m	time, ly opin	date and ion, deat	l place, a h occurre	and due to the ed at the time,	cause(s) date and	and manr place, an	ner as si d due to	tated. the cause(s)
To the vithin 2	сошо	Me	29b. Signature and title of certifier				29c. Lice				1			_	Day, Year)
in			30. Name and address of person who	completed cau		m 23a) (Type,		55	+37		•	Janu	ary 1	1,2	006
10	O.		Elizabeth Bower 31. Date filed (Month, Day, Year)		Registrar's Signa		y Woo	lsk	sek, t	MD	21163				
Re	Sta gistra		JAN 1 3 20		Cipar A	K Ans	de								

		·	State of Maryla			•	vaiene	
		1 - For Stata Registrar	Otate of Maryta		ate of Death	d Wentai i	Reg. No. 0 0 6	00566
- A		Decedent's Name (First, Middle, Last)				2. Date of Month		3. Time of Death
Physicia /Medic		David M.	Million			Janua	ry 10 200	
Examin	er	4a. Facility Name (If not institution, give s	11	46.0	City, Town, or Location of C	Death	4c. County of Dea	ath
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs	s. last birthday) If Ur Mon	ider 1 Year If Under 24			thplace (State or Foreign
Director		233-70-7200	M 2□ F 57	7 Yrs.	hs Days Hours	Nov.	15,1948Wes	stVirginia
yland Now		Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Location		<u>-</u>		10d. Inside City Limits
e Mar Sa-f st	ctor	MD Baltin	nore	Middle R	iver			1 ☐ Yes 2€ No
with th	Dire	10e. Street and Number 20 Maxa Court		10f.	Zip Code		10g. Citizen of What C	ountry?
5-0036 72 hours after death with the Maryland natural; or fema 23a or 28a-f show dideal Examinant by notified at	Funeral Director		2. Was Decedent Ever in I	U.S. 13. Was De	21220 ecedent of Hispanic Origin specify Cuban, Mexican, P	? (Specify Yes or I	USA No- 14. Race - Am	erican Indian,
j 2 3		1 Never Married 2 Married	Armed Forces? 1∰Yes 2 ☐ No If Yes, Give	_	specify Cuban, Mexican, F s 2 1 No <i>Specify:</i>	uerto Rican, etc.)		
5-0036 72 hours after "natural", or the	ed by	3 ₩idowed 4 Divorced	Year or Dates:				Specify: W	
	Completed	15. Decedent's Educ (Specify only highest grade	completed)	16a. Decedent's l (Give kınd ol life. DO NO	Jsual Occupation ' work done during most of 'T use retired)	working	16b. Kind of Business	,
id 2121 stiled within Hygiene. other than "	Com	ciementary/secondary (0-12)	College (1-4or 5+) 4yrs	Pipe	Fitter		Domino Su	ıgar
be tile	Be	17. Father's Name (First, Middle, Last)					le, Maiden Sumame)	
re, Maryland 21215-0036 s 1 and 2 should be tiled within 72 hours af it Health and Mental Hygiene. Item 27 is marked other than "natural", or other traumatic event, the Madical Exam	To	Loren M. Millio 19a. Informant's Name/Relationship (Type		19b. Mailing Add	ress (Street and Number of	A. Arr	on	Zin Codel
		Ruth Rehill/sis			Ichabod La			
		20a. Method of Disposition 1 ☐ Burial 2 ☐ € remation 3 ☐ Re	20b.	Place of Disposition (cemetery, crematory	Name of or other place)	Date	20c. Location · City or	Town, State
Baltimo		4 □ Donation 5 □ Other (Specify)	D	ayviewCr		/11/06	Baltimore	∍ MD
Bal permit Depar Impor any in		21. Signature of Funeral Service License	onnell	·	and Address of Facility Mace Av	Connell Balt	yFuneralHo	meofEssex
		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused the dea	Do not enter the	mode of dying, such as car	diac or respiratory	arrest,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)		HIPOX	A			Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):	PSIS			2640
	Jer	Sequentially list conditions, b.	Due to (or as a conse					
and transi	Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
760, te be execul ysicien and ne burial-trar	cai E	rosuming in assum, case	Due to (or as a conse	quence ot):				
687 tiflicate g phys as the		d.						
is, P.O. Box 68760, es that the death certificate be executed igned by the attending physicien and be detached for use as the burial-transit	by Physician/Med	230. Was decedent prognant	Bc. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet		c pregnancy		23d. Date of de	livery
o. Bo	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of 9☐ Unknown				Month	Day Year
ecords, P.O. law requires that the as been signed by the	Ph	Part II. Other significant conditions cont	tributing to death but not re	sulting in the underlying	og cause given in Part I	23e. Dio	I tobacco use contribute to	the cause of death?
rds, quires n sign	d b							robably 4 ⊡Unknown
Vital Records, sician: The law requires tertificate has been signe rector, page 2 should be or	Completed					24a. Wa	is an 24b. Were a	utopsy findings available completion of cause of
The The page	Com					per	formed? death?	completion of cause of
of Vital F Physician: Th this certificate ral director, page	Be	25. Was case referred to medical examiner?	ospital:		26. Place of Other: 4 Thursday	Death Check only	оле	
Of Phys or this aral dii	To To	1 Yes 2 No	28a. Date of Injury	28b. Time of	DOA 4 Nursir		sidence 6 Other (Spe how injury occurred	icify)
Vision Attending r death. ctor: After	atio	1 ∰Natural 5 ☐ Pending investigation	(Month, Day Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No			
	Medical Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Spec	nome, farm, street, fac ify)	tory, office	28f. Location City or T	(Street and Number or Riown, State)	ural Route Number,
Diversities of the Hospitel or within 24 hours after To the Funerel Director completely filled in its	aj Ce	29a. Certifier 1 ☐ Certifying Phys	ici an: To the best of my kn	owledge, death occur	red at the time date and n	ace and due to th	e cause(s) and manner a	s stated
he Ho n 24 h ha Fu pletely	edic	one) 2 Medical Examin	er: On the basis of examin and manner stated.	ation and/or investigat	ion, in my opinion, death o	occurred at the time	a, date and place, and due	to the cause(s)
To t To t	Σ	29b. Signature and title of certifier			29c. License number		29d. Date signed (Mont	**
1,		teli			05800	9	Jan 11 h S	Look
10		30. Name and address of person who cor	npleted cause of death (Ite	m 23a) (Type, Print)	FARES IDA	0	Herica Mi	0 200
Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	quare Di	105-10	dimer 1"	V 5.00
Registra	ar	JAN 1 3 2008	Marie Si	The state of the s				

Million, David

Amend item#206,perff, 350, 1713, in Flack Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 1 January **Physician** Year erry Miller 11:53 PM 2006 /Medical 4a. Facility Name (It not institution, give street and number)
University of Maryland Medical Center 4b. City, Town, or Location of Death 4c. County of Death **Examiner** falt more, Maryland NA If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Birthplace (State or Foreign Country) Days Year) 1 **⊠** M 2 ☐ F 43 Yrs. 220.76.2293 Director 05.18.1962 MD Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "natural", or Items 23a or 28a-f show other treumatic event, the Mudical Exprend intest by political NIA Director MD BALTIMORE 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3125 BRIGHTON STREET 21216 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Mever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 Widowed 4 Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be illed within 7.
Department of Health and Mental Hygiene.
Importent: If item 27 is marked other then "ns any njury or other treumstic event, the Mental Once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CAR DETAILER NA 12 TH GRADE SELF EMPLOYED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) SAMUEL L. MILLER HARRIETI TAYLOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PHILLIP MILLER (BROTHER) 3125 BRIGHTON ST., BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1/13/06 1 ☐ Burial 2 SCremation 3 ☐ Removal from State ' 4 □ Donation 5 □ Other (Specify) GREENMOUNT BALTIMORE MD 21. Signature of Fuperal Service Licensee 22. Name and Address of Facility CREMATION SERVICES augh 5151 BALTO. NATL' PIKE, BALTO. MO 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** & cardial Infarction /Medical Dus to (or as a consequence of): Examiner revsus host diserse month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be executed burial-transit machny Due to (or as a conseque Division of Vital Records, P.O. Box 68760, attending physician for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 2- No 1 Yes or Attending Physicien: after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No 2 To the Hospitel or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Manuar of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimera, Greene Street 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JAN 1 3 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Yeer Month Day **Physician** 1,2006 HENRY JANUARY /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner BAHIMORE
If Under 1 Year If Under 24 Hrs.

Hours Min. OSPI HAL Johns 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Days Hours 1 M 2 F -36-9278 212-36-927 Usual Residence of Deceder Director 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits permit. Peges 1 end 2 should be filed within 72 hours after deeth with the Marylan Depertment of Heelth and Mental Hydene. Important: if item 27 is marked other than "neturel", or items 23a or 28a-f show any injury or other freumatic event. It a Madical Examinating must be notified at once. 1 91es 2 No Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 100 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ 10 If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 NORTH WOODINGTON RD. BAUTIMORE, MD 21229 SAYLE 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State HANOVER. ANATOMY GIFTS KEG 4 Conation 5 Other (Specify) 21. Signature of Figneral Service Licensee 22. Name and Address of Facility MUNTON' GIFTS REGISTRY 75.22 CONSTRESOR, HANOURR MD 21076 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 40URS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner IURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner that initiated events to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ۵ 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Medicai Certification; 5 Pending investigation 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide

led by the attending physicien and detached for use as the burial-transit Division of Vital Records, P.O. n signed by to icate has been sig r, page 2 should b After this certificate has or Attending Physicien: s efter death. efter within 24 hours e To the Funeral To the Hospital completely

3altimore, Maryland 21215-0036

State Registrar

7

(Check only one)

29b. Signature and title of certified

30. Name and address of person

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

000

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

29c. License number

N. WOIFE STREET, BALTIMORE

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** JANUARY 12.2006 2:30 A M Lillian Mildred Moores /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Saint Joseph Medical Center Towson 8. Date of Birth Oct. 18, 1914 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 213-36-94-7 1 M 2 TF 91 Yrs Maryland Director Usual Residence of Decedent death with the Maryland 10d, Inside City Limits 10c. City. Town or Location 10b. County 10a. State r 28e-f ehow 1 Tes 2 No Reisterstown Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number r than "natural", or items 23a or the Medical Evant, or must be a 1924 Knox Ave. 21136 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ੴ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status fited within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 White ģ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Homemaker 18 Mother's Name (First Middle Maiden Sumame) 17. Father's Name (First, Middle, Last) iit. Pages 1 and 2 should be filk ariment of Health and Mental Hy ortant: if item 27 is marked oth injury or other treumatic event John Daniel Armacost Lillian Constantine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John B. Moores - Son 2716 Appleseed Rd., Finksburg, Md. 21048 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ABurial 2 Cremation 3 Removal from State permit. Page Department Important; if eny injury or once. Evergreen Mem. Gardens Jan. 16,2006 Finksburg, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
ECKHARGE Funeral Chapel 21. Signature of Funera 23a. Part1. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate Immediate Cause (Final disease or condition resulting in death) a ACUTE MYOCARDIAL INFARCTION Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physicien and s the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical ettending p IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 2 No 1 TYes 3 Probably 4 Unknown CONGESTIVE HEART FAILURE Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ② Y No as 2 25. Was case referred to medical examiner? 26. Place of Death | Check only Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 2 this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: After 1 XNatural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of sertifier 06 D 37254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7 OSLER DAINE 10.00 10.00 2.24 Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

		Please 1 - For State Registrar	State of Mary	land / Depa		lealth and Mo	•	99 106	00570		
Physici /Medi		1. Decedent's Name (First, Middle, Las	Mitchel				2. Date of Death Month	Day Yeer	3. Time of Death		
Examir		4a. Facility Name (If not institution, give Balfinore VA	Street and number)	Center	Baltin	r Location of Death	'	4c. County of Dea	ith		
Funeral Director		5. Social Security Number 6. Sec. 503-09-7859	9x 7. Age (Ir XIM 2□F	yrs. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Y 07/27/19	9. Bi 18 Ne	thplace (State or Foreigr ountry) braska		
Maryland 1 show	or	Usual Residence of Decedent 10a. State 10b. County MD Cecil			10d. Inside City Limits 1 Yes 2 No						
with the Part or 28a-	Director	10e. Street and Number		Perryvil	10f. Zip Code		10g	. Citizen of What C	ountry?		
ified within 72 hours after deeth with the Maryland Hygiene. Whygiene. Wher than "natural", or items 23a or 28e-1 show one. The Maryland Example in unit be notified at	by Funeral	507 Cedar Point Dr 11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 XYes 2 \(\sqrt{No}\) If Yes, Give Year or Dates: \(\lambda(\lambda(\lambda))		Was Decedent of H If Yes, specify Cub	i dispanic Origin? (Spe an, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	te, etc.		
n 72 hours af "natural", or	leted	15. Decedent's Ed (Specify only highest gra-	ucation	16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	during most of working	ng 16	16b. Kind of Business/Industry			
II C I C	e Completed	Elementary/Secondary (0-12) 1 2 th 17. Father's Name (First, Middle, Last)	College (1-4or 5+)		tain	18. Mother's Name		I.S. Army	,		
Id be ental ked o	To Be	Samuel T. Mitchell 19a. Informant's Name/Relationship (1)		10b Maili	ing Addross (Street	Elsa Smi		The or Town State	Zin Code)		
C = M F		Mary G. Park- Comp	anion	507	Cedar Pt.	Dr., Per	ryville.	-	3		
DallIMOTE, permit. Peges 1 ar Depertment of Hea Important: If Item any Injury or othe once.		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ '4 □ Donation 5 □ Other (Specify	Hemovai from State	R.A. Fer	osition (Name of matory or other pla TUS & CO.	01/10	106 We	st Chest			
Darmit. Depermit. Depermit. Import	1	21. Signature of Funeral Service Licen	500 Smit	\rightarrow 12	2 Name and Addre Mitchell- 3 S. Wash	Smith Funding ton. He	eral Home avre de (, P.A. Grace. Mi	21078		
Physician /Medical Examiner		Pert1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a co	iration		mg, such as cardiac o	r respiratory arrest	,	Approximate Interval Between Onset and Death		
be executed ician and burial-transit	ilcai Examiner	g d									
The Collas, T.C. BOX 001 The law requires that the death certificate the has been signed by the attending physoge 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of d Month	elivery Day Year		
res that the de signed by the a	र्व	Part II. Other significant conditions of	ontributing to death but n	ot resulting in the t	underlying cause gr	ven in Part I.			to the cause of death?		
The law requires to the has been signed age 2 should be of	Completed	diabetes ne	litus				24a. Was an autopsy performe	d? prior to	autopsy findings available completion of cause of		
	Be Co	25. Was case referred to medical examiner?				26. Place of Death		<u>1 □ Ye</u>	s 2 100		
Physic Physic or this ce	²	1 Yes 2 No	Hospital: 1 Impatient 28a. Date of Injury	2 ER/Outpatie	nt 3LI DOA		ne 5 Residence 28d. Describe how	e 6 Other (Sp injury occurred	ecify)		
To the Hospital or Attending Physician: within 24 hours after deeth. To the Funeral Director: After this certified completely filled in by the funeral director,	Certification:	1 Natural 5 Pending Investigation 3 Suicide 4 Homicide Femilied		- At home, farm, st	M 1	Yes 2 □No	28f. Location (Stree City or Town, S		Rural Route Number,		
Hospita 4 hours Funeral ely filled	edicai Ce	29a. Certifier 1 Certifying Ph	ysician: To the best of m niner: On the basis of ex and manner stated	amination and/or in							
To the Vithin 2 To the Complet	Med	29b. Signature and title of certifier	The manner states		29c. Licen			. Date signed (Moi			
10+1		30. Name and address of person who Michael MC(completed cause of death		Print)	17211	Ja + Bull	mary C	10 2120		
St	ate	31. Date filed (Month, Day, Year)	32. Registrar's		do			1	10		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#19a,perfff.Q351,1/20/06 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 12:47 P M Murray Jan 9 Augela 2006 /Medical 4c. County of Death 4b City Town or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Fort Washighton

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth

Min. | Min. | Month, Day, Year)

Fight 1, 1922 Fort Washington Hospital Prince George's 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🖫 F Months 83 Yrs. 155-10-1182 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a. State r than "natural", or items 23s or 28s-f show the Medical Evand on much be collined at 1 ☐ Yes 2 ☑ No Maryland Frince George's Clinton Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 20735 13105 Gallahan Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: if item 27 is marked other than "na any injury or other traumatic event, Ita Made once. (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Finisher Manufacturing 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Antoinette Naro Calla Salvatore 19a Informant's Name/Relationship (Type, Print)
Thomas Murray
Wichael Sidarous (Son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13105 Gallahan Road Clinton, Maryland 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Jan. 13. 1 Burial 2 □ Cremation 3 □ Removal from State Trenton, New Jersey St. Mary's Cemetery 2006 * 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility of File and I the had 21. Signature of Funeral Service Licenses 6633 04 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Parumonia **Physician** disease or condition resulting in death) Week /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events been signed by the attending physician and should be detached for use as the burial-transit certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐ Pregnant at time of death 5 Cther (specify) P.O. 1 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown RKINSONISM Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? this certificate 1 ☐ Yes 2FTNo funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: 1 Impatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification; To 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death al or Attending P After 1-Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours all To the Funerai Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai completely (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D45365 01-10-2006 livingstoned Hill freashipton Mo 2014 & 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Sidaerus M.O 11701 31. Date filed (Month, Day, Year) 3. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JAN 1 3 2006

MCQUINN ANDE

			Please Type or Print in Black Indelible ink. Ensure All Copies Are Legible.
			State of Maryland / Department of Health and Mental Hygiene 0 0 5 7 2
			Registrar COTIMOGIC OF DOGITH REG. No.
			1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year
1	Physici: /Medic		ANNE F. McQuinn JANUARY 7 2006 9.05PM
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
1			BALTIMURZ WARHINGTON MEDICAL CENTER CILEN BURNIE ANNE ARUN DEL
	Funeral		5. Social Security Number 6. Sek / 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign
	Director	Į	215-03-1412 10M 2 FF 91 Yrs. Months Days Hours Min. (Month, Day, Year) Country)
	g		Usual Residence of Decedent
	how		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □ Yes 2 ⊡ No
	B Ma	cto	Md. HANE HELASTI MITEROUTE
	or 28)Ire	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	23a	Funeral Director	8312 Suppyview Drive 21108 U.S.A.
	dea	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
9	or its	F	1 Never Married 2 Married 1 Sec. 1 No Specify: Specify: Specify:
5-0036	72 hours after death with the Maryland natural; or Items 23a or 28a-f show iteal Espoirer must be notified at	Completed by	3 ₩idowed 4 Divorced Year or Dates:
5-0	72 h natu	etec	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working Ille. DO NOT use retired) 16b. Kind of Business/Industry
21	within ene. than "	n jd	Flomentary/Secondary (0-12) College (1-40r 5+)
7	filed w Hygier thar th	S	1 Homemaker Own Home
pu	tal H d oth	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
<u>Va</u>	Men Men Marke Marke	2	JUSEPH GABOR MARY KRYLOWICZ
Maryland	and and lam		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	1 and Health am 27 other tr		David McQuipn-Son 8312 Surpriew DR. Millersville, Nd. 21108
ore	ages 1 int of He t: If itar y or oth		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State
Ĕ	Pag nent ant: I		· 4 Donation 5 Other (Specify) Bayuiew Crematory Baltimore, Maryland
Baltimore,	permit. Pages Department of Important: If I any Injury or one		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service P.A.
m	89559		Jame granecouleston Ritchie Huy. Baltimore, Nd. 21225
			23a-Part1. Enter the disease, occomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
	Physician		Immediate Cause (Final Cause (F
7	/Medical		disease or condition resulting in death) Due to (or as a consequence of):
	Examiner		GRANARY ARTERY DISEASE
,		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Cause (Disease or injury)
ž –	uted d ansit	Examiner	Cause (Disease or injury that initiated events c. CONCESTIVE HEAR TAILURE
o T	be execut sician and burial-tran	Еха	resulting in death) Last Due to (or as a consequence of):
760	eath certificate be executed attending physician and for use as the burial-transit	cai	d
89	certificate nding phys use as the	Physician/Medi	
Вох	andin use	N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 23d. Date of delivery
	death a atte d for	icia	in the past 12 mionths? 4 Pregnant at time of death 5 Other (specify)
P.O.	that the di ed by the detached	hys	9 Unknown 9 Unknown
	res tha igned I be det	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
ğ	n sig	d b	1 Yes 2 No 3 Probably 4 Winknown
8	w requires been si should l	iet	24a. Was an 24b. Were autopsy findings available
Division of Vital Records,	The law requires that the death are has been signed by the atter page 2 should be detached for u	Completed	autopsy prior to completion of cause of performed death? 1
TO .		0	25. Was case referred to medical 26. Place of Death (Check only one)
>	ysician: is certific director,	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat/ent 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
of	Phys		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred
on	iding Phi th. : After thi funeral	tioi	1 Aatural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No
2	Attendii death. ctor: A	fica	3 Suicide 6 Could not be 28e Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number,
S	after Dire	Certification;	4 ☐ Homicide determined building, etc. (Specify) City or Town, State)
	Hospital or Attending Physician: 4 hours after death. Funaral Director: After this certificitely filled in by the funeral director,		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	To the Hospital or Attent within 24 hours after deatl To tha Funaral Director: completely filled in by the	Medical	(Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To the within 2 To tha complet	Me	29b. Signature and other 29d. Date signed (Month, Day, Year)
	->-0		15/ Shaber MD 125149 ANNARY 7 2003
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
	Le		30. Name and address of person who combleted cause of death (Item 23a) Type, Print) OHABAD 301 HESpitel Drive alen Burne MD 21061
	Sta	ete	31. Date filed (Month, Day, Year) 32. Registrar's Signature
	Regist		1AN 1 3 2006 See & Sparke
		004	JAN 1 3 2006 January 15 January 1

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) mere 2006 **Physician** 08 TANU /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE
If Under 1 Year | If Under 24 Hrs. HARBOR pita 1105 Birthplace (State or Foreign Country) Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min 19M 20F Yrs MARYLAND 214-24-9670 Director October 28, 1928 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a State item 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Machical Experience must be excited at 1 ☐ Yes 2 ☐ No Director BURNIE ANNE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? S.A. 203 WAY 6503 21060 Condo Be Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ es 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1946 Baltimore, Maryland 21215-0036 1 Yes 24No Specify. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) National BREWERS DRIVER 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental and Mental MEYERS OEhM REDERICK CATHERINE 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Md. 21060 item 27 WITE G.B. MEYERS Condo 203 HOMEWATER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date City or Town, State 20a Method of Disposition 20c. Location to = 1 DBuriat 2 Cremation 3 Removal from State ō Department of Important: If any injury or MEADOWRINGE MEM. PARK Jan. 12,2006 ElkridgE * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatore of Funeral Service Licensee 22. Name and Address of Facility GONCE SERVICE P.A. FUNERAL once Ritchie erome BAHO. nomucall 4001 HWY. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Fart1. Enter the disease or comshock, or heart failure. List only Approximate Interval Between Onset and Death tmmediate Cause (Final CARDIOPULMONARY **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SECON DARY

Due to (or as a consequence of): 10 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed use as the burial-transit OBSTRUCTIVE LUNG Box 68760. the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year jo in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) P.O. page 2 should be detached 9 Unknown ğ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 Pres 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 2 No 1 ☐ Yes Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one, examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 1 Inpatient ٩ 1 Tes 2 NO 3 DOA his 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After Hospital or Attending 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only

completely within 2

State

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) Registrar

29b. Signatur

titue of certifier

3 2006

32. Registrar's Signature 134 E

3001

and manner stated

s of person who completed cause of death (Item 23a) (Type, Print)

UUUSMA

29c. License number 4204 29d. Date signed (Month, Dav. Year)

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DHMH 17 Rev 1/2001

Registrar

3 2006

			For State	State of N		d / Dep		t of H	ealth a		lental Hy	giene	UUU	0057	5
	Physici		1. Decedent's Name (First, Middle,	Last) Mers	-1//	00	imcat	012	Joann		2. Date of De Month	Day	Yea		ath O M
	/Medio Examin		4a. Facility Name (If not institution, g Future Care	Nursing (cente	9ry	4b. City,	h_	Ball Ball	ima	sie.	J 4c.	County of D	eath Birthplace (State or Fo	vreian
	Funeral Director		5. Social Security Number 6 215-03-5039 Usual Residence of Decedent	1□M 200F	95	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da 06-17-19	ay, Year) 911	Sc	outh Carolina	_
	Maryland a-f ehow	tor	10a. State 10b. County MD NA		10c. City	y, Town or Lo Balt	imore							10d. Inside City L	
	or 284	Director	10e. Street and Number				10f. Zip						izen of What	Country?	
	s 23a	eral	3023 Ridgewood Ave	nue 12. Was Deceder	nt Ever in U.	S. 13.		21215 dent of Hi	spanic Orio	gin? (Spe	ecify Yes or No		JSA 14. Race - A	merican Indian,	
980	urs after de al', or ttem Examiner	by Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Force	s? XINo		If Yes, spec		n, Mexican Specify:	, Puerto	ecify Yes or No Rican, etc.)		Black, W	Inite, etc.	
21215-0036	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "netural", or items 23a or 28a-f ehow amy injury or other traumatic evant, the Medical Examiner must be notified at ODGE.	Completed by Funeral	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4c)	or 5+)	(Give	dent's Usua kind of wo DO NOT us	rk done d se retired	turing most	t of worki	ng	16b. K	ind of Busine		
121	iled w tygier ther ti	ပိ	3 17. Father's Name (First, Middle, La	ast)			Press	ser	18. Mothe	r's Name	First, Middle	. Maiden	Laundr Sumame)	У	
Maryland	ould be f Mental H arked of	To Be	Doc Edgerton			T				M	Mary Sin	ms			
Mar	d2sh thand thand 7 is m traum		19a. Informant's Name/Relationship Connie Williams/ D				_				<i>l Route Numb</i> .timore,N			e, <i>Zip</i> Code)	
Baltimore,	Peges 1 an ent of Heal nt: If item 2 ry or other		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		te c	lace of Disponentery, cre	matory or c	ther plac)1–16–	2006		cation - City	or Town, State	
Balti	permit. I Departm Importer any inju		21. Signature of Funeral Service Li		1	1	2. Name ar Wylie E			-	638 N.C		•	Balto, MD 2	1217
	Physician /Medical Examiner	iner	23a. Part1. Enter the disease, or coshock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	- a Athe		clero	1.				crespiratory a	di:	SCASE	Approximate Interval Betwee Onset and Deal	n th
د 68760, حو	that the death certificate be executed ed by the ettending physicien and detached for use as the buriat-transit	Medicai Examiner	Lause (Disease or Injury that initiated events resulting in death) Last	d	necur as a conseq	-	19_							TWIC	
P.O. Box	law requires that the death certifica as been signed by the ettending ph 2 should be detached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 1 No 9 □ Unknown	23c. If yes, outcon 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 ☐ Feta at time of d	I death 3	□Ectopic pa □ Other (sp						23d. Date of Month	delivery Day Year	
	w requires that the second second by the second be detach	þ	Part II. Other significant condition	s contributing to death	n but not res	ulting in the u	underlying o	ause give	en in Part I.	-			use contribut	e to the cause of deatl	
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Vital	Physician: this certific ral director.	Be	25. Was case referred to medical examiner?	Hospital:		ER/Outpatie		Othe	05		n <i>(Ch</i> eck only me 5 ☐ Res		s DOthar /S		
n of	ng Physiter this	on: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	1 ☐ Inpa 28a. Date of In (Month, I		28b. Time of Injury	of 2	28c. Injun	/ at k?		28d. Describe			specify	
Division of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	ot be 28e. Place of	Injury - At ho etc. (Specif	ome, farm, si	M treet, factor		Yes 2□I		28f. Location (City or To			r Rural Route Number,	
	n Hospita 124 hours a Funera	dicai	29a. Certifier (Check only one) 12 Certifying 2 Medical E	Physician: To the be xaminer: On the basis and manner	s of examina	owledge, dea ation and/or in	th occurred nvestigation	at the tim	ne, date an pinion, dea	d place, th occurr	and due to the ed at the time,	cause(s) , date and	and manner d place, and	r as stated. due to the cause(s)	
	Toth within Toth comp	Mc	29b. Signature and title of certifier	N Mace	n	MD	29	c. License	1 5	50	3	29d. Da	te signed (Mi	onth, Day, Year)	6
	4		30. Name and address of person w	M MI	9 EEN	7,5	Print)) at	phir	7 5	+ B-	110	MC	a1917	_
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)		istrar's Signa	aturé	de la	/							

	ŀ	For State Registrar	State of Man	yland / [Departmer Certifica			Mental Hy	Reg. No.	00576
Physici /Medic		1. Decedent's Name (First, Middle, L Jeanne		rqui	55			Month	Day	Year 3. Time of Death
Examir		4a. Facility Name (If not institution, go Howard Count	y General H	ospita	21 45. City	olumi	ocation of Dea			vard.
Funeral Director		5. Social Security Number 6. 545-36-5840	Sex . 7. Age (// 1 ☐ M 2X F	ii yis. iasi bii	Yrs. Months	Days	Hours Mir	. (Month, D	ay, Year)	Birthplace (State or Foreig Country)
pu s		Usual Residence of Decedent 10a. State 10b. County	1		m or Location			April 5	, 1929	California 10d. Inside City Limit
Maryla	tor		loward			Fllid	cott City			1 ☐ Yes 2 N
or 288	Director	10e. Street and Number	TOTAL CONTRACTOR OF THE PROPERTY OF THE PROPER		10f. Zi	Code			10g. Citizen of Wi	
eath w	erai	3004 North Ridge Rd.	12. Was Decedent Eve	er in U.S.	13. Was Dece	dent of His	21043 panic Origin? (Specify Yes or Norto Rican, etc.)	0- 14. Race	U.S.A American Indian,
be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show evant, it wedged Frain increases.	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?		If Yes, spe		Mexican, Pue Specify:	rto Rican, etc.)	Specify:	, White, etc. White
72 ho	eted	15. Decedent's (Specify only highest g		16a	Decedent's Usu (Give kind of w life. DO NOT t	ork doné du	on ring most of w	orking	16b. Kind of Bus	iness/Industry
d within 72 hours at giene. er than "natural", or the Medical Evalu	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		1116. DO 1401 C		emaker		1	Own Home
be filed w tal Hygier d other th	Be C	17. Father's Name (First, Middle, Las	it)			1	8. Mother's Na	ame (First, Middle	, Maiden Sumame)
d 2 should be filed the and Mental Hygi R7 Is marked other traumatic event,	ပ	Myron 19a. Informant's Name/Relationship	Edwin Hill	194	Mailing Addres	s (Street an	d Number or F		Helen Whee	1874
nd 2 state at the contract of		Mrs. Terri Switlick							Maryland 2116	2023
rrit. Pages 1 and 2 partment of Health portant: If itam 27 1 y injury or other tra		20a. Method of Disposition 1 Burial 2 Cremation 3		20b. Place of	of Disposition (Na ry, crematory or	me of		Date		City or Town, State
perrit. Pages Department of Important: If it any njury or o		`4 □Donation 5 □Other (Spec	cify)	All Cour	nty Cromation	n Servi	ees, Inc. 0	1/13/2006	Sykes	sville, Maryland
Department of the same of the		21. Signature of Fuheral Service Lic	166 Min	135		Slack Fu	meral Hori	ne, P.A.		
death certificate be executed death certificate be executed e attending physician and for use as the burial-transit	ical Examiner	disease or condition resulting in death) Sequentially list conditions, any learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a c b. Due to (or as a c c. Due to (or as a c d.	onsequence	of):					
death certific e attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of 1□Live birth 2 [4□ Pregnant at tirn 9□ Unknown	☐Fetal death	3 □Ectopic p 5 □ Other (s		N	/A	23d. Date Mont	of delivery h Day Year
quires that	by	Part II. Other significant conditions History of b	reast Can 'asculity's	not resulting i	n the underlying	cause given	in Part I.	_	_	oute to the cause of death? B □ Probably 4 □Unknow
The law requires that the rate has been signed by the page 2 should be detacht	Completed	History of v	asculitis					24a. Was auto perfe 1 Yes	psy pri ormed? de	ere autopsy findings available for to completion of cause of ath? Yes 2 No
Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:					eath (Check only	one)	
ding Phys h. After this funeral di	tion; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigat	28a. Date of Injury (Month, Day Y	2 □ ER/O(28b.		28c. Injury a Work?	4 🗀 Nursing		idence 6 Other	
To the Hospital or Attanding Within 24 hours after death. To the Funeral Diractor: After completely filled in by the fune	Certification;	3 Suicide 6 Could not determine	be 290 Place of Injuny		arm, street, facto	y, office			Street and Number wn, State)	r or Rural Route Number,
To the Hospital within 24 hours a To the Funeral (completely filled	edical (29a. Certifier 1 Certifying 8 (Check only one) 1 Medical Ex.	Physician: To the best of raminer: On the basis of examiner states	amination ar d.	nd/or investigatio	n, in my opir	nion, death occ	curred at the time,	date and place, an	id due to the cause(s)
To th Within To th compl	Me	29b. Signature and title of certifier	Va.	m.D.	29	c. License	number	,	29d. Date signed	(Month, Day, Year)
1		•	Vom.			V5	653	I	Jan.	05,2006
4		1.001.1	780 Htcko	th (Item 23a)	idge R	d,	Lolum	bia, 1	nDale	(Month. Day, Year) 05,2006 044
St Regist	ate rar	31. Date filed (Month, Day, Year) JAN 1 3 20	2. Registrar's	Signature	Goods					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#26, perMD, C851, 1/13/06 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 8:38A.M **Physician** Bernard Lancelot Neal, 4, 2006 Jan. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Sinai Hospital Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** 1 € M 2 🗆 F 47 218-76-4736 9,1958 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. Count 10a. State show r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be nutified at 1 ☐ Yes AGNo Essex Maryland Baltimore Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21221 1414 Straw Flower Road death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Patuxent Medical College (1-4or 5+) other than Elementary/Secondary (0-12) Mail Clerk Center 11th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 end 2 should be tile Department of Health and Mental Hy Important: If Item 27 is marked othe any liquy or other treumatic event, page. Ida C. Jones Bernard L. Neal, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4003 Norfolk Avenue Baltimore, Maryland21216 Ida C. Jones-Neal/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1-11-06 1 ➡Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn, Maryland King Memorial Park 22. Name and Address of FacilityChatman-Harris Funeral Home 21. Signature of Funeral Service Licens 5240 Reisterstown Rd Baltimore,Maryland Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ONGENTIV **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical îhe as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ YPERTENTION, VIABETES 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed WORBID OBESITY 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy 1□ Yes Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient XX DOA 1 🗌 Yes 2 No 4 ☐ Nursing Home 5 ← Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Magner of Death Certification: 1 Natural 2 Accident Injury 5 Pendina 1 TYes 2 No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified CONME who completed cause of death (Item 23a) (Type, Print) arthall 6450 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Mandora Noble Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06 - 0233State of Maryland bepartment of Health and Mental Hygiene AKG 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2006 Year **Physician** Mandora Noble January 9 1:45 P /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facifity Name (If not institution, give street and number) Examiner n/a Baltimore 3129 East Monument Street 8. Date of Birth (Month, Day, Year) June 3, 1966 ff Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 200/F Months Director UNK Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show rthan "natural", or itema 23s or 28s-f sho the Medical Executes must be notified at 1 Tes 2 No Bultimore MD by Funeral Director NIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21205 E. Monument USH 3129 filed within 72 hours after death Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☑No tf Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritaf Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: 3 9 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Colfege (1-4or 5+) Factory Laborer other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be . Pages 1 and 2 should be fill thent of Heelth and Mental H tant: If Itam 27 is marked ott jury or other traumatic aven Virsalena)ames 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Refationship (Type, Print) Baltmone, MD Ursalena Noble Siune I mother 2118 Avenue 20b. Pface of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or once. akeside Cemekry Dover Delawing 16/06 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Service, P.A. Funeral Close Fur Baltmone MO 21206-5105 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** a Mixed Alcohol and Drug (Heroin and Cocaine) Intoxication /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Examiner ettending physicien and for use as the burial-transit Hospital or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the deteched 9 Unknown cete has been signed page 2 should be de Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 X¥es 2 No 1 Yes 2 □ No Division of Vital 25. Was case referred to medical examiner? 26. Pface of Death (Check only one) director Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) at scene 2 1XXes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time Find 28d. Describe how injury occurred unk 27. Manner of Death Certification: 1 Natural 5 Pending 1:30 P after death.
I Diractor: Af 1 ☐ Yes 2X No investigation 2 Accident 1/9/06 6 Could not be 28f. Location (Street and Number or Rural Route Number. City or Town, State) 3129 E. Monument Street Baltimore City, MD 3 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Found Residence within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) 32. Regist JAN 1 3 2006

10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

O.C.M.E.

111 Penn Street, Baltimore, Maryland

January 10, 2006

			1 - For State Registrar	State of Mar	yland /				d Mental Hy	1	11116	00579
				Al .		Certif	icate of D	<i>Jealli</i>	2. Date of De	Reg.[No	000	3. Time of Death
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	/Medic	al	Pauline 4a. Facility Name (If not institution, give		3.	41	OVe		eath	40	County of Deat	
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	Funeral		5. Social Security Number 6. S		In yrs. last		Under 1 Year	If Under 24)	Frs. 8 Date of Bir	th	9. Birt	hplace (State or Foreign
	Director			□ M X XF	77	Yrs.	onths Days	Hours M	lin. O 2. O		28	NC
	pu ,		Usual Residence of Decedent 10a State 10b County	1	Oc City To	own or Locati	20					10d. fnside City Limits
	anyla ehov	5	10a. State 10b. County NA		-	timo						1⊈Yes 2 □No
	28e-f	ect	10e, Street and Number		במם		Of, Zip Code			10a. Cit	izen of What Co	••
	with Sa or	2	1027 Cathedral	Street A	Apt 2	2F	212	201			U.S.A	
	death me 2:	Funeral Director	11. Maritaf Status	12. Was Decedent Eve					(Specify Yes or No Jerto Rican, etc.))-	14. Race - Ame	
9	or Ite	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give			Yes 2 No	Specify:	ierto Aicari, etc.)		Black, Whit	
21215-0036	be filed within 72 hours after death with the Maryland niel Hygliene. ed other then "neturel", or Iteme 23a or 28e-f ehow event, the Medical Esarular must be notified at	d by	3 X Widowed 4 ☐ Divorced	Year or Dates:							<u> </u>	Black
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an	should be nd Mentel marked c	To Be	Nicholas Smith	Sr.				Alven	ia Brew	er		
Maryland	2 should be and Mentel te marked eumatic ev	-	19a. Informant's Name/Relationship (1	9b. Mailing A	ddress (Street a		Rural Route Numb		or Town, State, 2	Zip Code)
	₽ = 2 = 1	1	Hilda Bouldin-S	Sister					. Road,			21244
ore	ges 1 ar it of Hea if item or othe		20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place ceme	of Disposition of the o	on (Name of ory or other place)	Date	20c. L	ocation - City or	Town, State
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Baltimore,	permit. Pages. Department of It Important: If Ite ony injury or of		21. Signature of Funeral Service Licen	see /		Ma i	ame and Address	of Facility West	;			
	å □ ≒ • q		Tour 10 a	ren	a death C	430	00 Waba	sh Av	e, Balt	imo	re, Md	21215 Approximate
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945	Physician /Medical		fmmediate Cause (Final disease or condition resulting in death)	a COMONA	ry	HITCH	m 12	islas				
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Вох	The law requires thet the death certifical ate has been signed by the attending phypage 2 should be detached for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2	☐Fetal dea		opic pregnancy				23d. Date of del Month	ivery Day Year
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P.0	thet the dead by the detached	h h	Part II. Other significant conditions of	ontnbuting to death but	not resultin	g in the unde	rlying cause give	n in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
ds,	uires l signe Id be	d by							1 🗆	Yes 2	□No 3□Pr	obably 4 Onknown
Records,	w requir been si should	Completed							24a. Was	an	24b. Were au	utopsy findings available
Re	he lav e has age 2	m c								psy ormed? 2 No	death?	completion of cause of
Vital		0	25. Was case referred to medical					26. Place of	1 ☐ Yes Death (Check only		1 10103	2010
<u>></u>	Physician: this certific ral director,	To B	examiner? 1 Tes 2 No	Hospital: 1 Inpatient	2 🗀 ER/	Outpatient	3 DOA Othe	-	ig Home 5 ☐ Res		6 ☐Other (Spe	cify)
Jo L	ding Ph h. After th funeral		27. Manner of Death	28a. Date of Injury (Month, Day)	(ear) 281	b. Time of fnjury	28c, fnjury Work	at ?	28d. Describe	how inju	ry occurred	
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Division	or Attendated after death Director: A	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Pface of Injury building, etc.	y - At home (Specify)	, farm, street,	factory, office		28f. Location (City or To			ural Route Number,
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	To the within To the Comple	₩.	29b. Signature and title of certifier-			_	29c. License	number		29d. Da	te signed (Mont	h, Day, Year)
	->-0			2		0	89	557		1	-8-01	D.
	3		30. Name and address of person who	completed cause of dea	th (Item 23	a) (Type, Pri	nt)	001				
			Megan Jacks	un m.D.	0/01	Marul	and Ge	neral	HasoHa			
	Sta		31. Date filed-Month, Day Ten 1	3 2005 Registrar	's Signature	No.	P. W.	- •	/			
200	Regist	rar		-		All S	Will All					

		•	1 - For State Registrar	State of N	Marylan		rtment of H tificate of L			Reg. No.	16 (00580
	Physici	20	Decedent's Name (First, Middle, Last)						2. Date of De. Month	Day	Year	3. Time of Death
	/Medic		THOMAS MARTIN	O'MALI					JANUAF			12:15P. [™]
	Examin	er	4a. Facility Name (If not institution, give st	treet and numbe	r)		4b. City, Town, or ROCKVILI		eath	4c. County	y of Death SOMERY	
			10 INFIELD COURT 5. Social Security Number 6. Sex	7. A	ae (In vrs. I	last birthday)	If Under 1 Year	If Under 24 h	Irs. 8. Date of Birt	h		ace (State or Foreign
	Funeral Director			M 2□F	80	Yrs.	Months Days	Hours N	June 8,	y, Year)	Count	sylvania
2	σ		Usual Residence of Decedent									
	arylar show	_	10a. State 10b. County			y. Town or Lo	cation				10	0d. Inside City Limits 1X Yes 2 □ No
	Be-1	ecto	Maryland Montgomer	СУ	Roc	kville	104 7i- Code			10- Chi	NA/h an Causal	
	a or 2	ă	10e. Street and Number 10 Infield Court Se	ou+h			10f. Zip Code 20854			10g. Citizen of United		
	eath	erai		2. Was Deceder	nt Ever in U.	S. 13. V		spanic Origin?	(Specify Yes or No		ce - America	
21215-0036	be illed within 72 hours after death with the Maryland ital Hygiene. Id other then "natural", or items 23a or 26e-f ehow event, the Madral Examination could be notified at	by Funeral Directo	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces 1 XYes 2 If Yes, Give Year or Dates	5? 7 No		Yes, specify Cuba	n, Mexican, Pu Specify:	(Specify Yes or No rerto Rican, etc.)	Bla Specif	ck, White, e fy: Wh	ite
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and m	0 m 2 >	Be	17. Father's Name (First, Middle, Last) William P. O'Malle	237					Clarty	Maiden Sumai	ne)	
Maryland	should be ind Menta marked umetic ev	မ	19a. Informant's Name/Relationship (Typ	,		19b. Mailin	g Address (Street a		Rural Route Numbe	er. City or Town.	. State. Zip	Code)
<u>8</u>	end 2 s ealth an n 27 ie ser treu	H	Paul O'Malley/son	-, ,					th, Rockv	-		354
ē,	一工三年		20a. Method of Disposition			lace of Dispos	sition (Name of natory or other place		uary 10,	20c. Location		wn, State
Ë	Pages nent of I int: if its iry or o		1 ☐ Burial 2 🕅 Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from Stat			Crematoriu	m 20	006	Bethesc	la, Ma	ryland
Baltimore,	permit. Page Depertment of Important: if eny injury or once.		21. Signature of Funeral Service Licenses William A. Hung	shuly	M011	73 ²² Ro	Name and Address bert A. P 00 W. Mont	s of Facility umphrey gomery A	Funeral Hor	ne, Rocky kville, N	ville, Marvlan	Inc. d 20850
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caus	ed the death							Approximate Interval Between
•	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Ath	eroscie as a consequ		zardiovasci	uker di	Slase			Onset and Death
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<i>ک</i> 	ate be executed hysicien and the burial-transit	хап	that initiated events resulting in death) Last		ıs a consequ	uence of):				_	-	
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ecords, P	w requires that been signed to should be deta	ρ	Part II. Other significant conditions cont	tributing to death	but not rest	ulting in the ur	derlying cause give	on in Part I.		obacco use cont res 2 □ No	tribute to the	e cause of death? ably 4 Dunknown
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Ö	Phys rthis ral di	٠ <u>.</u>	1 ☐Xres 2 ☐ No 27. Manner of Death	28a. Date of In	iurv	ER/Outpatient 28b. Time of	3 DOA	4 Nursin	g Home 5 ☐ Resid	lence 6 <u>X</u> IOth now injury occur) SCENE
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Division	r Attandi tar death. irector: A irector: A	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of I	njury - At ho	me, farm, stre	eet, factory, office	87100	28f. Location (S City or Tox	Street and Numb	er or Aural	Route Number,
בֿ	s efte at Dir	Cert	4 El Tomicido	Dallowing,	etc. (<i>Specif</i>)	·/			City of 100	m, olulo)		
	To the Hospitel or At within 24 hours efter of To the Funaral Direct completely filled in by	Medicai	(Check only one)	er: On the basis and manner:	of examinat	wledge, death tion and/or inv	estigation, in my op	o, data and ph inion, death o	ace, and due to the courred at the time,	date and place,	annar as eta and due to	the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. License	number		29d. Date signe	d (Month, D	Day, Year)
			- Lamol Frither	1, mi			0.C	.M.E.	J	ANUARY	6, 20	06
	146:		30. Name and address of person who cor	npleted cause of	f death (Item	23a) (Type, I	Print)	CIDIO LICO	DAIMINA	THE MATERIA	ANTO O	1001
_	10		taingle E. Suthai	1,mD				STREET	BALTIMOR	LE MAKYL	AND Z	1201
	Sta Registr		31. Date filed (Month, Day, Year)	32. Regis	strar's Signa	ture	BI					
	riegisti	eri E	JAN 1 3 2006	A STATE OF S	1 18	Man					-	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00581 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Jan 12, 2006 Year **Physician** 11:00A M Patricia Lee Pfisterer /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Annapolis Anne Arundel Medical Center 8. Date of Birth

(Month, Day, Year)

June 10, 1968 Birthplace (State or Foreign Country)
 MD If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Funeral 1 M 2 F Min. Hours 37 220-02-0157 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-f show the Medical Examiners wat be notified at 1 ☐ Yes 2 ▼No Director MD Anne Arundel **Arnold** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21012 USA 238 1443 Baltimore Annapolis Blvd death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 本本No If Yes, Give Year or Dates: 14. Race - American Indian, 'natural', or Items 11. Marital Status Black, White, etc. filed within 72 hours after Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXo Specity: Specify: White δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If Item 27 is marked other than eny Injury or other traumatic event the second in the s Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Diane J. Blotkamp Charles L. Pfisterer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 13478 Pullman Dr, Spring Hill, FLA 34609 Charles L. Pfisterer Father 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 TCremation 3 ☐ Removal from State Jan 13, 2006 Baltimore, MD Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Compasses Fink funeral Home, P.A. Oregory Tink 426 Crain Hwy SW, Glen Burnie, MD 21061 Approximate Interval Between Onset and Death Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician acute on incett /Medical Due to (or as a consequence of): Examiner alcobolic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Exam that initiated events and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ate has been signed by the attending physicien page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9. Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 🗌 Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy this certificate has 2/No 1 Tes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Tes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Alaturai 5 Pending death. 1 ☐ Yes 2 ☐ No ours after death. neral Director: A filled in by the fu 2 Accident investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 24 hours a Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2. To the F 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1-12-2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aunojelis 31. Date filed (Month, Pay istrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dev Year January 2006 551C 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Name (If not institution, give street end number) Center ville Norsing Frederick Villa Age (In yrs. lest birthday) 2 Yrs. If Under 1 Year Birthplece (State or Foreign Abuntry) Social Security Number 6. Sex 120 Davs Hours Months 1□M 205F 216-32-1203 Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10e. Stete 10b. County 1 Yes 2 □ No more land 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 212 29 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) 5 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) 0 Johnson Thnie 19a. Informant's Name/Relationship (Type, Print Granddaugh Dieb. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 20b. Place of Disposition (Name of cametery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Memoria 2004 4 Donation 5 ☐ Other (Specify) tai 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph L. K Home, P.A. Joseph L. Russ Fi 2222 W. North Ave. Funeral e. Balto nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or e consequence Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dug to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 🗆 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 20 No Hospital: Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗆 Yes 27. Menual of Death Netural 28d. Describe how injury occurred 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 5 Pending investigation

Be Completed by Physician/Medical Examiner or Attending Physicien: The lew requires that the death certificate be exacuted Division of Vital Records, P.O. Box 68760 tor: After this certificate has been signed by the attending phys the funeral director, page 2 should be deteched for use as the Medical Certification: To within 24 hours efter death. To the Funerel Director: A

Physician

/Medical

Funeral Director

Completed by

Be

Examiner

Funeral

Director

Peges 1 and 2 should be filed within 72 hours efter death with the Meryland nent of Health and Mentel Hyglene.

ant: If Item 27 is marked other than "naturel", or items 23e or 28e-1 show ury or other treumatic event, the Medical Examiner must be notified at

Department of important: if its eny injury or o

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

1 ☐ Yes 2 ☐ No 28f. Location (Street end Number or Rural Route Number, City or Town, State)

knowledge, death occurred at the time,	date and place,	and due to the	cause(s) and ma	anner as state	id.
ninetion end/or investigation, in my opin	ion, death occur	red et the time,	date and place,	end due to the	e cause(s)

		<u> </u>
29b. Signature and title of certifier	1/	0
	X	favolution

2 Marcal Examiner: On the basis of exam

29c. License number

29d. Date signed (Month, Day, Yeer) 006

30. Name end address of person who

State Registrar

filled in by

Hospital

To the

2 Accident

3 Suicide

29a, Certifier

4 - Homicide

31. Date filed (Month, Day, Year) 2006 3

00

6 Could not be determined



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

М

			1 - For State Registrar	State of Maryland /	Department of F		Mental Hygie	2006 6	10583
			Negistrar Name (First, Middle, Last)		00.10410 0	20001	2. Date of Death		3. Time of Death
	Physici		CLARA M.	Phebus			JANUARY	Day Year 2006	6:00 AM
	/Medic Examir		4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, o	r Location of Death		4c. County of Death	\ \ \ \
				CAD North		دسم		11	sunde 1
	Funeral		5. Social Security Number 6. Sex	M 2 F 7. Age (In yrs. last t	ointhday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	ar) 9. Birthpl	ace (State or Foreign try)
	Director		Usual Residence of Decedent	10			DECEMBER 1	\$ 1915 MA	ayland
	yland		10a. State 10b. County		wn or Location			10	Od. Inside City Limits
	Ba-f	cto	Md. ANNE H	RUNDE! Lin	thicum				1 ☐ Yes 2 ☐ 110
	vith th	Director	10e. Street and Number	0 1	10f. Zip Code	000	10g.	Citizen of What Count	ιry? 1
	eath v	Funeral	122 LONG CROSS	2. Was Decedent Ever in U.S.	th 210		ecify Yes or No-	14. Race - America	1 •
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936	72 hours after death with the Maryland natural; or Hems 23a or 28a-1 ehow Jical Examinat must be motified at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No	Specify:		Specify: Wh	ITE
21215-0036	d within 72 hours after death with the Marylan Jiene. r than "natural", or Items 23a or 28a-1 ehow I'le Medical Esta circutal be notified at	Completed	15. Decedent's Educ (Specify only highest grade		Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	ation during most of work	ing 16b	. Kind of Business/Ind	ustry
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	J 5 6		17. Father's Name (First, Middle, Last)		WHITE		e (First, Middle, Maid		SE - CHE ENIT
an		To Be		Ll., K	now)		GARET	Webse	20 +2 =0
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Baltimore,	T in		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	an an an an an an an an an an an an an a	of Disposition (Name of tery, crematory or other place		Date 20c	. Location - City or Tov	wn, State
Ĕ	Pa men ant: ury		`4 □Donation 5 □Other (Specify)	Glen	HAVEN MEM.	PARK JAN.	11,2006 G	len Brenie	EML.
Salt	permit. Pag Department Important: i any injury o		21. Signature of Funeral Service License		22. Name and Addre	iss of Facility	NIE FINE	tral Servi	CE PA.
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			shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.		ig, such as cardiac	or respiratory arrest,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Polum m.					
	Examiner			Due to (or as a consequence	Inha Phil	Disen.			
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Division	il or Attending after death. Director: After in by the fune	fica	3 Suicide 6 Could not be	28e. Place of Injury - At home,			28f. Location (Street	and Number or Rural	Route Number,
á	al or alter	Certification:	4 Homicide	building, etc. (Specify)			City or Town, St	ate)	
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in b			ician: To the best of my knowled er: On the basis of examination a					
	within 24 To the Fi	ledicai	one)	and manner stated.					
	To To	Σ	29b. Signature and title of certifier	16 2	29c. Licens			Date signed (Month, D	-
•	1		Cult	ran 2	<i>V</i> -	/ 7 7 /	1	on, 4	2000
	5		30. Name and address of person who cor	Commented cause of death (Item 23a	10 0 S	Con.	he ont	on, 9 100 Cohn	mllin
	Sta	te_	31. Date filed (Month, Day, Year)	32. Registrar's Signature	, con	1-4 0-11			21216
	Registi	-	JAN 1 3 2006	Seemen A Com	the state of the s				•

			1 - For State Registrar	State of Maryland / [tment of Ho			ene	6	00584
	Physici	an	1. Decedent's Name (First, Middle, Last)	Jagdish Prasad				2. Date of Death Month		Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give st			4b. City, Town, or	Location of Deat	January	10, 2		12:10 PM
	Examin	er	Holy Cross Hospita			Silver			i	gomer	·y
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last bir		If Under 1 Year Months Days		8. Date of Birth (Month, Day, Feb. 8,	Year) 1929	9. Birthp Coun In	lace (State or Foreign try)
			Usual Residence of Decedent	10c. City, Town		****					
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	the N	Directo	Maryland Prince Ge 10e. Street and Number	orge b		10f. Zip Code		10	g. Citizen of	What Coun	itry?
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	r deet	Funerai	11. Marital Status	2. Was Decedent Ever in U.S. Armed Forces?	13. W	as Decedent of His Yes, specify Cuban	spanic Origin? (S n, Mexican, Puerl	pecify Yes or No- o Rican, etc.)		ce - Americ	
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auc	d be f ental k ked ol	To Be	Nand Kishore				Ram K			,,,,	
Baltimore, Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after deeth with the Maryland to f Health and Mental Hygiene. If Item 27 is marked other than "naturel", or iteme 23a or 28a-f show or other traumatic event, the Madical Examinar must be notified at	-	19a. Informant's Name/Relationship (Type		. Mailing	Address (Street a	nd Number or Ru	ıral Route Number,	City or Town	, State, Zip	Code)
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	permit. Page Depertment of Important: If eny injury or once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Seven Licensee	Cremat	oriu	ım. Inc.	200)6° B6			ryland da-Chevy
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			23a. Part1. Exter the disease, or complic shock, or heart failure. List only one	ations that caused the death. Do recause on each line.							Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	Progression of		e Myelog	enous L	eukemia			
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		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	of):						
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ROX	death certific e attending p id for use as	an/M	230. Was decedent pregnant	c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 □E	ctopic pregnancy				ite of delive	
О.	at the dea by the att	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of death 9☐Unknown		Other (specify)			Me	onth	Day Year
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Ĭ		Com						perform 1 ☐ Yes 20	ed?	death? 1 Yes	
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Division of Vital Records,		Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	ırm, stree	et, factory, office		28f. Location (Stre City or Town,		ber or Rura	l Route Number,
-	pital ours en consideration of the consideration of		29a. Certifier 1 Certifying Physi	cian: To the best of my knowledge	death o	occurred at the time	e date and place	and due to the cau	use(s) and m	anner as st	ated
	To the Hospital or within 24 hours effe To the Funerel Dir completely filled in	edicai		er: On the basis of examination an and manner stated.							
	To the vithir To the comp	Me	29b. Signature and title of certifier	1 .		29c. License			d. Date signe	7	
	4		· Candau L.	Wille ND		2000	61937		1/10	106	
	50		30. Name and address of person who com	pleted cause of death (Item 23a)	(Type, Pr	rint)	- 611-1	D) 50	VER	500	NU main no
	Sta	to.	31. Date filed (Month, Day, Year)	32. Registrar's Signature	00	FUKES!	GCEN	10,012	. ren	J F/()/	VE, IVIDICAN
	Registr		JAN 1 3 2006	32. Registrar's Signature	and in	,					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day PALLOZZ1 Month Year **Physician** 16.44PM MORRIS 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL COLUMBIA HOW ARD How man COVNIT If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 MM 2□F Hours 66 Director 148.28.0399 April 25, 1939 New Jersey Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County in than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Ellicott City Marvland Howard 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21043 4321 College Avenue by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. U.S. Govenment College (1-4or 5+) Elementary/Secondary (0-12) Attorney 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jennie M. Maas Morris N. Pallozzi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) s 1 and 2 s if Health an item 27 is 4321 College Avenue Ellicott City, Maryland 21043 Spouse Ms. Julie Pallozzi

20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If itel
any injury or otf 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/11/2006 Baltimore, MD Bayview Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Part 1. Enter the dise of the complications that caused the death. Do not enter the mode of dying, such as carriac or respiratory arrest, which, or heart failure. List only one cause on each line. Munterless -Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ENCEPHALOPATHY **Physician** ANOXIC /Medical Due to (or as a consequence of): Examiner SEPS15 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician and ned for use as the burial-transit NEWITUS DIABETED Due to (or as a consequence of): Box 68760 DISEASE RENAC Physician/Medical STAME IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 I ive birth 2 Fetal death in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by ENDUCARDITIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? HISTORY CARDIAC 24a. Was an autopsy performed? this certificate 1 ☐ Yes 2 ☑ No 1 Yes 2 No Be (25. Was case referred to medical examiner? uneral director, 26. Place of Death (Check only one) Hospital: 1.⊿1npatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification; To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Injury 1/ Natural 5 🗌 Pending 1 ☐ Yes 2 ☐ No investigation 2 T Accident after death 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier JAN 2006 ATTENDING 000,8948 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PLACE SUITE 34, BALTIMORE MO 21201 JANE CANOTADA 20 300 ARMON 31. Date filed (Month, Day, Year) 32º Registrar's Signature State JAN 1 3 2006 and see it Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				State of Maryla State of Maryla Registrar		rtment o				Reg. No.	06	00586
		Physicia	an	. Decedent's Name (First, Middle, Last)					2. Date of De. Month	Day	Year	3. Time of Death 8:00 PM M
		/Medic	al	George Carl Reeves, Jr. a. Facility Name (If not institution, give street and number)		4b City Tox	wn orl	ocation of Death	Januar		2006 ty of Death	8.00 PM W
		Examin	er	Harford Memorial Hospital		40. Oily, 100		avre de		Harf		
		Funeral			rs. last birthday)	If Under 1 Y		If Under 24 Hrs.	8. Date of Bird	th Voor	9. Births	place (State or Foreign
		Director		218-01-3179 1SM 2 F 85	Yrs.	Months D	ays	Hours Min.	(Month, Da 10/10/	1920	MD Coul	
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		daath with the Maryland rms 23a or 28s-f ehow r nwat be notified at	Completed by Funeral Director	11 Marital Status 12, Was Decedent Ever in	U.S. 13. V	Was Deceden	t of His	panic Origin? (S	pecify Yes or No o Rican, etc.)	- 14. Ra	ace - Americ	
	9	or ite	Fur	Armed Forces? 1 Never Married 2 S Married 1 S 2 S No If Yes, Give		tYes, specπy 1□Yes 2□		Specify:	o Hican, etc.)	1	ack, White,	
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1	5	72 h "natu	ete	15. Decedent's Education (Specify only highest grade completed)	(Give	ient's Usual C kind of work o DO NOT use r	done du	on ring most of wor	rking	16b. Kind ol Agricu		•
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0	d 2	filad Hygia ther	ပိ	17. Father's Name (First, Middle, Last)			1	8. Mother's Nar	me (First, Middle,	Maiden Suma	ime)	
20	an	lid be lantal ked c	To Be	George Carl Reeves, Sr.				Mary Mo	oxley			
	Maryland	shou and N		19a. Informant's Name/Relationship (Type, Print)					ural Route Numb		n, State, Ziç	Code)
		end 2 salth in 27 i		Muriel R. Reeves/Wife				Frankf	ord, DE			
90/6	ore	of He of He or oth		20a, Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State	p. Place of Dispos cemetery, cren	sition (Name natory or othe	of er place)	i	Jan 11	20c. Location	•	
16	Ë	Pag tmant tant: jury c		4 □Donation 5 □Other (Specify) C	hesapeal			- '	2006	Beltsv	rile,	Maryland
	Baltimore,	parmit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Marrial Hygiana. Important: If item 27 ie marked other then "natural", or items 23a or 28s-f show eny injury or other traumatic event, the Marcical Examinating the notified at ODCs.		21. Signature of Funeral Service Licensee	C		on a	nd Funera	al Altern Drive F		e, Mar	ryland
				23a. Part1. Enter the disease, or complications that caused the de shock, or heart lailure. List only one cause on each line.	ath. Do not ente	er the mode o	of dying,	such as cardiad	or respiratory a	rrest,		Approximate Interval Between
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				K. Deeni, M	A.		D	6270	4	J · }}	. 200	6
				30. Name and address of person who completed cause of death (tem 23a) (Type,	Print)	040	OBPAKE	Healm	Bel	AIX	MD
					gnature /	- C (Y)030	Tun	, - (1), -	/		21014
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	Physicia /Medic	an	1. Decedent's Name (First, Middle, Las Josephine Rash	()					January	13, 2006	3. Time of Death
	Examin		4a. Facility Name (If not institution, give				4b. City, Town, Bel A	or Location of Death		4c. County of Deal	
			Upper Chesapeake 5. Social Security Number 6. Se		. Age (In yrs. las		If Under 1 Year		8. Date of Birth	Q Rie	hplace (State or Foreign
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0 0	or Items	by Funeral	1 Never Married 2 Married	Armed Ford	es? ! X No		Yes, specify Cut □ Yes 2 X No		Rican, etc.)	Black, White Specify: W	
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e, 6	of Heelth Item 27 other tr		20a. Method of Disposition	cicer tue			sition (Name of natory or other pla			20c. Location - City or	Town, State
(A) P	ages ant of nt: If It		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		tate		natory or other pil 4 Redeem		12006	Baltimore,	Maruland
/ Baltir	permit. Pages Department of Important: If It any Injury or o		21. Signature of Funeral Service Licen		/	22	. Name and Add	ess of Facility Sch	imunek F	uneral Hon	
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Œ	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edical C	29a. Certifier 1 Certifying Ph (Check only 2 Medical Example)	ysician: To the niner: On the ba and mann	sis of examination	ledge, deat on and/or in	h occurred at the vestigation, in my	time, date and place opinion, death occu	, and due to the correct at the time, d	ause(s) and manner a date and place, and du	s stated. e to the cause(s)
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			1////	11	2			7746		1-13	-06
	10		30. Name and address of person who Dr. Thomas Burke,	, 501 S.	Union,	Ave.,	Rm.207,	Havre de	Grace,	MD 21078	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) JAN 1 3 200	6 032. Re	egistrar's Signati	Tre Aller	E)				

DHMH 17 Rev 1/2001

Registrar

			For State Registrar		State o	f Marylar		artment o				giene	6	00589
90	2		Decedent's Name (Fi	irst, Middle, Last)							2. Date of De	ath		3. Time of Death
	Physicia		Albert	R	ichard		Schoe	berleir	ı		Januar	v 10. 2	906	7:50 A M
	/Medic		4a. Facility Name (If not						m, or Location	of Death		4c. Count		
	-		2806 5th St	treet				Miller	s Isla	nd		Bal	timor	re
	Funeral Director	6	5. Social Security Numb 217-38-5580	10	(]M 2□F	7. Age (In yrs.	last birthday) 65 Yrs.		ear if Unde lys Hours		8. Date of Bir (Month, Da October	ay, Year)	Cou	place (State or Foreign intry) yland
Pu	> ::		Usual Residence of Dec	b. County		10c Cit	ty, Town or Lo	neation						10d. Inside City Limits
aryla	Show	ž		Baltimor	e		llers							1 ☐ Yes 2X No
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with 1	0 9	Funeral Director	2806 5th St					212				USA	villat ood	
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	10		30. Name and address	of person who co	ompleted cau		п 23а) (Туре,	Deint)			180-50N	NO 21		
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 11^{Day} 2006 **Physician** Jä'n 2:45pm Μ. Catherine Serio /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Stella Maris - Towson Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🙀 F 213-30-6160 75 July18,1930 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 7 is marked other then "naturel", or iteme 23s or 28s-f show traumatic event, the Modical Examinational be notified at MD 1 Yes 2 No Baltimore Director Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2234 Hamiltowne Circle USA Be Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) own home Homemaker 12±h 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If item 27 is marked othe eny liquy or other traumatic event gota. 17. Father's Name (First, Middle, Last) Thomas B. Spurrier Theresa R. Amaco 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles A. Serio /husband 2234 Hamiltowne Circle Baltimore Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Woodlawn Cemetery 1/14/06 1

Burial 2 □ Cremation 3 □ Removal from State Baltimore MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee ConnellyFuneralHomeofEssex 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 300 Mace Ave. Baltimore MD 21221 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician DEMENTIA** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires thet the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Month Day Year 4 Pregnant at time of death 5 Other (specify) be detached P.0 the 9 Unknown 9 Unknown cete hes been signed by , page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No 1 Yes 2 No of Vital the funeral director. 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 ☐ Yes 2 🛣 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural
2 Accident 5 Pending investigation 1 Yes 2 No within 24 hours efter death.

To the Funeral Director: A completely filled in by the fu 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospitei 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: So the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of dertifier 11/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIMONIUM, MD 21093 DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 1 3 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

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CATHERINE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 - For State Registrat Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) JAMOARY Pb. 20126 10:15FM **Physician** /Medical 4c. County of Death Baltimore 4a. Fecility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death Examiner Towson Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year, **Funeral** 235.05.9359 1□M 20F Yrs. Director WEST Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location rthan "natural", or itams 23a or 28a-f ehow Ita Medical Examinar must be notified at 1 ☐ Yes 2 No TARFORT Directo JARREI 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21084 edus. Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Yes 2 No 1 Never Married 2 Marned 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ith and Mental h TOWELL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ARRETISVILLE MDZIOSA Pages 1 and 2 ment of Health a WILLIAM HUSBAN 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Depertment of Important: If eny injury or once. MEMORIN 4 ☐ Donation 5 ☐ Other (Specify) 2006 1510N HIGHUIEW 21. Signatus of Funeral Service Licensee 22. Name and Address of Facility 03 FOLKERL CHAPEL. PELAIR HILL, MD 21050 61220 Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease Immediate Cause (Final disease or condition resulting in death) INTRACEREBRAL HEMORRHAGE **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physicien by Physician/Medical the use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths?
1 Yes 2 No
9 Unknown Month Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No CORONARY ARTERY DISEASE Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an HYPERTENSION autopsy performed 2 No 2 No 1 Yes Director: After this certific d in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) spital: 1 Inpatient 2 [28a. Date of Injury (Month, Day Year) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: X No 1 Tes 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de To the Funeral Directo completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a, Certifier and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of continer D 31826 with ficul -10-06 Fr C 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) QSLER DRIVE TOWSON, MARYLAND 21204 M. D. . 7601 RICHARD LINTHICUM, 32. Pegistrar's Signature 31. Date filed (Month, Day, Year) State 3 2006 JAN 1 Registrar

DHMH 17 Rev 1/2001

		Amend item	18 per fh g8 State of Maryla			of Health and of Death		(14 m)	00592
		Registrar		Cei	nificate (or Death	2. Date of De	Reg. No.	3. Time of Death
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/Medi		John		Stri	icklan		Januar	7.11	
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		Sinai Hospital o	0	s. last birthday)			U	th 9	Birthplace (State or Foreign
Funeral Director		217-20-2575	x QM 2□F 79	Yrs.	Months D			15 26	Country) MD
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anyla •ho	5		T	Baltimo	oro				1 XYes 2 No
the A	Funeral Director	MD NA 10e, Street and Number		OG I CIM	10f. Zip Co	de		10g. Citizen of Wha	t Country?
with a or	ā		. Ant 311			21215		U.S	Α.
eath	era	3000 Towanda A	12. Was Decedent Ever in	U.S. 13.	Was Decedent	of Hispanic Origin? (S Cuban, Mexican, Pue	Specify Yes or No		American Indian,
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tal H	Be	17. Father's Name (First, Middle, Last)	_			Annie			
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es 1 and 3 of Health filtem 27 ir other tr		20a. Method of Disposition		Place of Dispo	osition (Name	of .	Date	20c. Location - City	
		1 XBurial 2 Cremation 3	Removal from State	cemetery, cre	matory or other	r place)	1/10/06		
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		shock, or heart failure. List only of	ne cause on each line.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		,g,	,		Interval Between Onset and Death
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r Atte	tific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, st	treet, factory, o	ffice	28f. Location (. City or To		r Rural Route Number,
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the Prin 24 the F		one)	and manner stated.			cense number		29d. Date signed (A	
To To Con	Σ	29b. Signature and title of certifier				RES-000	,		
11/1		*	edical Docto					January	0,2006
511		30. Name and address of person who	completed cause of death (I	tem 23a) (Type	, Print)	ALIPIALLO 1	Baltimore	, MD 21	215
Santa Maria da		SI. Date filed (Month, Day, Year)	32. Registrar's Sig	***	VIGETO	FIVENUE C	ALT THO C	, , , , , ,	-1 ~J .
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			1 - For State Registrer	te of Maryland / [Department of Health Certificate of Dea		giene 0 0 6	00593
ý	Physici /Medi		1. Decedent's Name (First, Middle, Last) Bitwhad Wiliphd	SCOTTA	SR.	2. Date of De Month	Day Year	3. Time of Death / F. '35 M
1	Examir		4a. Facility Name (If not institution, give street Harbor Hospital		4b. City, Town, or Locati Balto		4c. County of Death	
ć Spr	Funeral Director	7	5. Social Security Number 6. Sex 11X M 2	7. Age (In yrs. last bir 81	rthday) If Under 1 Year If Un- Months Days Hou	der 24 Hrs. 8. Date of Bi rs Min. (Month, D. 10-6-	rth ay, Year) 9. Birth Cou	place (State or Foreign ntry) Va
	Aaryland show	or	Usual Residence of Decedent 10a. State 10b. County Md N/A	10c. City, Tow Balto				10d. Inside City Limits 1 XYes 2 No
	with the h	al Director	10e. Street and Number 2847 Joseph Avenue		10f. Zip Code 2122	25	10g. Citizen of What Cour	ntry?
980	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23e or 28e-f show enty injury or other traumatic event, the Medical Examinar must be notified at ADGE.	by Funeral	11. Marital Status 1 Never Married 2 Married	is Decedent Ever in U.S. ned Forces? Xres 2 ☐ No es, Give ar or Dates:	13. Was Decedent of Hispanic If Yes, specify Cuban, Mex	Origin? (Specify Yes or Nican, Puerto Rican, etc.)	0- 14. Race - Americ Black, White,	
Maryland 21215-0036	od within 72 hogiene. griene. ar than "natu	Completed	12th grade		Decedent's Usual Occupation (Give kind of work done during rilife. DO NOT use retired) Machinist	nost of working	16b. Kind of Business/In Metal Co	•
yland	ould be file Mental Hy larkad oth	To Be (17. Father's Name (First, Middle, Last) Henderson Scott		Ch	other's Name (First, Middle naley Burman		
	1 and 2 sh Health and Im 27 is m ther traum		19a. Informant's Name/Relationship (Type, Pr Arbell Scott - Wife 20a. Method of Disposition		o. Mailing Address (Street and Nu 2847 Joseph Ave of Disposition (Name of		Md 21225 20c. Location - City or To	
Baltimore,	Department of I Important: if Its any injury or o		1 Burial 2 Cremation 3 Remove 4 Donation 5 Other (Specify) 21. Sunature of Funeral Serve Licensee	I from State cemete	ry, crematory or other place) on Cemetery 22. Name and Address of Fa	1/14/2006	Balto, Md	
Ä	Pe Pe	1 4	23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau	s that ceused the death. Do se on each line.	1	00 Wabash Ave		Md 21215 Approximate Interval Between Onset and Death
68760,	Physician Physician and phys	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence	OI): STETIOLETINA OI):	MAPETION Security Di	SUNPYE	
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Divis	ital or Atternations after the rail Directories in by the state of the	Certification:	4 Homicide	. Place of Injury - Al home, fa building, etc. (Specify)		City or To	Street and Number or Rura wn, State)	
	To the Hospital of within 24 hours af To the Funeral Completely filled in	Medicai	(Check only 2 Medical Exeminer: O	To the best of my knowledge to the basis of examination and ad manner stated.	e, death occurred at the time, date d/or investigation, in my opinion,	e and place, and due to the death occurred at the time,	cause(s) and manner as si date and place, and due to	tated. the cause(s)
	To th within To th	Me	29b. Signatuse and title of certifier	w)	29c. License numb	er 4 0 8	29d. Date signed (Month,	Day, Year)
	5X1		30. Name and address of person who complete 31. Date filed (Month, Day, Year)	005 dw	(Type, Print)	But Bon	an some	21730
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Amend 1 tem 1 per doc 8851 1-26-06 VL
State of Maryland / Department of Health and Mental Hygiene [] [] [

00594 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Jane Smith 1. Decedent's Name (First, Middle, Last) Norva Day Year Month **Physician** Norva Jean Smith 12:43 9 2006 Jan /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Baltimore 2541 W. Fairmount Avenue If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 ☑ F Yrs. 215-38-7315 63 Director July 10,1942 Maryland Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. Count or 28a-f show the Medical Examiner must be notified at N/AX☐ Yes 2☐ No Baltimore Director Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 238 21223 USA 2541 W. Fairmount Avenue Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items Black, White, etc. within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: Mever Married 2 Married Baltimore, Maryland 21215-0036 SpecifyBlack 1 ☐ Yes 2 No Specify: ð 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages 1 and 2 should be filed wire Department of Health and Mental Hygient Importent: If Item 27 is marked other that any injury or other traumatic event, Italian 2006. Private Family Domestic Engineer <u>11th grade</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy Wallace George Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dorothy Smith/Sister 811 N. Fremont Ave Baltimore, Maryland21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Woodlawn Cemetery1/14/06 Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licery 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 Approximate Interval Between Ons -t and Death 23a. Part1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. lumediate Cause (Final isease or condition resulting in death) LANCER Physician 5 months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the attending physicien Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the at d be detached fo 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1□ Yes 2 No To the Hospitel or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only on Be Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Injury at 28d. Describe how injury occurred Hospital: 1 Yes 2 No 1 fnpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 2 Accident 5 Pending 1 Tyes 2 No investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation in the cause of t 29a. Certifier Medical Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified D16354 13/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON ANE BALTIMORE MD AGNES 32. Registrar's Signature 31. Date filed (Morth Bay, Year) 2006 State Registrar

State
Registrar

31. Date filed (Month, Pay,

111 PENN STREET, BALTIMORE, MARYLAND 21201

leted cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day RICHARD Ε. SCHMIDT **Physician** 10 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore ruare HOSpital
7. Age (In frs. last birthday) Rosedale Franklin If Under 1 Year | ff Under 24 Hrs. 8. Date of Birth (Month, Day, 6. **Sex XX**M 2□ F 5. Social Security Number **Funeral** Months Min Hours 213-30-1602 74 Days Director 12-02-1931 Usual Residence of Decedent the Maryland 10a State 10h. County 10c. City, Town or Location item 27 is marked other then "naturel", or items 23s or 28s-f show other traumatic event, the Madical Examinar must be notified at MD. Director BALTIMORE PARKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1 RICHMOND AVENUE 21234 8607 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Kichar 2 should be filed within 72 hours after and Mental Hygiene. 1)Never Married 2 Married 1 Yes 2 No Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry MARYLAND STATE ROADS COMMISSION Elementary/Secondary (0-12) 12 YEARS College (1-4or 5+) DRIVER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Schmidt, JOHN С. SCHMIDT ROSINA G. GORDON ပ 19a. Informant's Name/Relationship (Type, Print) Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Depermit. Pages 1 and 2
Deperment of Health an.
Important: if item 27 ie m.
eny injury or other-ADELE S. WALTER (DAUGHTER) 8609 RICHMOND AVENUE, PARKVILLE, MARYLAND, 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XX Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) TIMONIUM, MARYLAND 01-14-2006 DULANEY VALLEY MEM.G. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility RUCK TOWSON FUNERAL HOME, INC. (R.G.RUTH) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#10e, 19a, per H. G51, 1/17/06 TI State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Physician /Medical Examiner

Examine

Physician/Medicai

δ

Be

2

1 Naturat

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and Intle of certifier

Certification:

Medical

Immediate Cause (Final

disease or condition resulting in death)

1 - For Stete Registrar

the attending physicien and hed for use as the burial-transit peen

page 2 should be detached certificate has the Hospital or Attending Physician: director, this in by the funeral after death. Director: After 24 hours a

Division of Vital Records. P.O. Box 68760.

diac Arrhuthmia a Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. Completed 25. Was case referred to medical examiner? Hospitaf: 1 Inpatient 2/ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of

erebra

Due to (or as a consequence of):

23e. Did tobacco use contribute to the cause of death?

23d. Date of delivery

Month

00596

9. Birthplace (State or Foreign

10d. fnside City Limits

1 Yes 2 100

ROAD

Year

Approximate Intervat Between Onset and Death

MARÝLAND

Year

2006

U. S. A.

14. Race - American Indian, Black, White, etc.

1050 YORK

TOWSON, MD. 21204

Day

WHITE

Specify:

3. Time of Death

07 PM

Reg. No.

21 No 3 Probably 4 Unknown 1 Yes

24a. Was an

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed 1□ Yes 2□No 26. Place of Death | Check only one

28d. Describe how injury occurred

28c. Injury at Work? M 1 Yes 2 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Printing Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

D54725

29d. Date signed (Month, Day, Year) 1/10/06

30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)

5 Pending investigation

6 Could not be

determined

Lopez,9000 Square Drive Baltimore MD 21237 Dr. Jose Franklin 31. Date filed (Month, Day, Year)

State Registrar

and manner stated.

To the within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | 1- State Registr Amend Item #18 Per FH C851 1/29/10/6/24 of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** January 11, 2006 11:58 P M Madeline Dolores Schmaus /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Center If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Yea April 15, ^{Year)}1923 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) 5. Social Security Number **Funeral** 1 □ M 2 🛛 F Märyland 82 Director 218-14-2757 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: if item 27 is marked other then "natural", or items 23a or 28a-f show with injury or other fraumatic event, the Macical Examinar mast be notified at once. 10a State 10b. County 1 ☐ Yes 2X No Director Parkville MD Baltimore 10g, Citizen of What Country? 10f. Zip Code 10e, Street and Number USA 21234 # 3309 8800 Walther Blvd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Never Married 2☐ Married White 1 ☐ Yes 2 X No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Proctor & Gamble Flementary/Secondary (0-12) College (1-4or 5+) Clerical Secretary 18. Mother's Name (First Middle Maiden Surname)
Eva J. Falljohann 17. Father's Name (First, Middle, Last) Be Henry Schmaus, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1642 Bond Road Parkton, Maryland Edward Schmaus/nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Constion 5 Other (Sec. 1997) Sacred Hrt. Of Jesus 101/16/2006 Baltimore, MD. Conation 5 Other (Specify) ature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Maryland 21204 Stephen Coster Stephen Loster 1050 York Road, 10650n, Mary 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final yea. Sunculatra Cancer **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, rany, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) use as the burial-transit Exami Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 glonths? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I \$ 2 1 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a. Was an autopsy performed 1 Yes 2 1 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death Check only one Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOS PLO 1 ☐ Yes 2 2 ER/Outpatient 3□ DOA Aftar thi funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only! 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier 29c. License number 58303 12 2006 dress of person who completed cause of death (Item 23a) (Type, Print) verles St Baltime AARON no

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Jamany II, 2006

MADELINE SCHMALLS

ORIGINA

32. Registrar's Signature

State Registrar ENG

30. Name and address of person who com

SIMONA

M. Registrar's Signature

100 E, CAYPOLI

of death (Item 23a) (Type, Print)

		For State Registrar	State of Ma	aryland	•	artment of rtificate of				giene 0	6 0	0599
Physici /Medic Examin	al	1. Decedent's Name (First, Middle, La Ivajean Carole 9 4a. Facility Name (If not institution, given Saint Joseph	Seim re street and number)	Dente	er.	4b. City, Town,		of Death	2. Date of Dea Month JANUAI	PY 9, E		3. Time of Death 11:45P
Funeral Director			Sex 7. Aga 1 □ M 2 💢 F	e (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Birth (Month, Day 02/23/1	r, Year)	Counti	ace (State or Foreig ry) Virginia
28a-f ehow	Director	MD Baltin 10e. Street and Number	more	10c. City,	Town or Lo	10f. Zip Code			1	10g. Citizen of		d. Inside City Limits 1 ☐ Yes 2√ No
jene. r then "natural", or items 23a or 28a-f ehow the Madical Examiner must be notified at	by Funeral Dir	12712 Fork Road 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 I If Yes, Give Year or Dates:			21051 Was Decedent of If Yes, specify Cult	Hispanic Ori oan, Mexicar			U.S.A	ce - America	ın Indian, tc.
i Hygiene. other then "natural rent, the Madical E	Completed	15. Decedent's Elementary/Secondary (0-12)	ducation ade com <i>pleted)</i> Col le ge (1-4or 5		(Give life.	dent's Usual Occu kind of work done DO NOT use retire	during mos				Business/Indi	
la de y	To Be	17. Father's Name (First, Middle, Last Charles E. Stee 19a. Informant's Name/Relationship	le		19b. Mailii	ng Address (Stree	Me	lvie	(First, Middle, I McCormi I Route Number	ick		Code)
Depertment of Health and Mer Important: if item 27 ie marke eny Injury or other treumatic once.		Richard F. Seim 20a. Method of Disposition 1 Burial 2 Cremation 3 [4 D nation 5 Other (Speci	Removal from State	сеп	ce of Disponetery, crei		Cem. (01/14 VE. 1	/2006 F. Lassa	20c. Location Baltimo ahn Fun	City or Tow Ore, M eral H	
ysician Medical Je priial-transit	ical Examiner	23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. SEFSIS Due to (or as b. Due to (or as c. Due to (or as	a conseque	nce of):	er the mode of dy	ing, such as	cardiac o	r respiratory arr	est.		Approximate Interval Between Onset and Death
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page 2	Be Completed by	25. Was case referred to medical					26. Place	of Death	24a. Was a autops perform 1 Yes	med? 241 No	prior to com death?	sy findings available pletion of cause of
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within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		4 Homicide determined	building, etch hysician: To the best of miner: On the basis of	of my knowl	edge, deat	h occurred at the t	ime, date an	d place, a	City or Town	n, State) ause(s) and m	anner as sta	ted.
within 24 To the F complete	Medical	29b. Signature and title of certifies	and manner sta			29c. Licen	se number			29d. Date signe		
Sta	ite	30. Name and a ress of person who are stated in the state of the state	7 C. [7] 1 C)	CLER	DRI	Æ TOWS	ON MO	RYLI	3ND 213	2014		

DHMH 17 Rev 1/2001

ORIGINAL

		•	For State	State of Man		ertificate of L			ene g. No. 006	00600
			Registrar 1. Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physicia		HERBER		MOND	SMITH		Janaury	9, 2006	10:58 AM
ł.	/Medic Examin		4a. Facility Name (If not institution, give s		HOND	4b. City, Town, or	Location of Death	2	4c. County of Death	
	Examin	er	Edward W. McCready		Hospita	Cri	sfield		Som	erset
	Funeral		5. Social Security Number 6. Sex	7. Age (/	In yrs. last birthday	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Births	place (State or Foreign
	Director		007 - 22-6556	XM 2□F	76 Yrs.	Months Days	Hours Min.	February 6	, 1929 Main	* *
	P		Usual Residence of Decedent		0c. City, Town or I	ti				I Od. Inside City Limits
	show	_	10a. State 10b. County	''	oc. Oily, Town of I					1 XYes 2 No
	Ba-f	Director	Maryland Somer:	set		Crisfiel	<u>d</u>	1.40	g. Citizen of What Cou	
	ith th	듬	10e. Street and Number			10f. Zip Code		10		ntry r
	death with the Maryland rms 23a or 28a-f show r must be notified at		103 S. Somerset A				1817	acity Van as Na	USA 14. Race - Americ	can Indian
	er de	Funeral	11. Maritar Status	12, Was Decedent Eve Armed Forces?	9r in 0.5.	. Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Black, White,	
30	hours after tural', or ite al Examina	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2 □ No If Yes, Give Year or Dates:	1930-	1 ☐ Yes 2 ☐XNo	Specify:		Specify: Wh	ite
5-003 6	n 72 hours after death with the Marylan "natural", or Nems 23a or 28a-f show edical Examinar must be notified at	ed	15. Decedent's Edu		16a. Dec	edent's Usual Occupa	ation	1	6b. Kind of Business/In	dustry
Ü	in 72 n nat	Completed	(Specify only highest grade Elementary/Secondary (0-12)		(Giv	e kind of work dorie of DO NOT use retired	luring most of work)	ing		
7	filed within Hygiene. other than	E	1 2	College (1-401 5+)	Unite	ed States	Coast Gua	ard [Jnited Stat	es Governme
0	il Hygi other	Be C	17. Father's Name (First, Middle, Last)					e (First, Middle, M		
Maryland	od and a second	P B	Raymond W. Smith				Mildred A	A. Scott		
a Z	2 shou and M is mar aumati		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Ma	ling Address (Street a	and Number or Rur	al Route Number,	City or Town, State, Zip	Code)
	as 1 and 2 should of Health and Me i item 27 is mark r other traumation		G. Alleyene Monkma	n (Compani				e - Crisf	ield, Mary	land 21817
altımore,	of He item		20a. Method of Disposition	lamaval from State	20b. Place of Disp cemetery, cr	position (Name of ematory or other place	9)	Date 2	0c. Location - City or To	own, State
Ĕ		1	1 ☐ Burial ZQCremation 3 ☐ P '4 ☐ Donation 5 ☐ Other (Specify)		Salisbur	y Cremator	y Jan.	12, 2006	Salisbury	, Maryland
<u>=</u>	permit. Page Department Important: Il any injury o		21. Signature of Funeral Service Licents	00 Velay - 24		22. Name and Address				
n	99 5 8 8		Mary Both Brad	shaw-Pruit					, MD 21817	
			23a. Part 1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the cause on each line.	e death. Do not e	nter the mode of dying	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			OLANGIO	CARCIN	OMA	Anni Anni ga Anni	Onset and Death
	/Medical		resulting in death)	Due to (or as a	consequence of):	001110	Critic City			
	Examiner		Conventially list conditions	0						
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oʻ	e exe ian a irial-1		resulting in death) Last	Due to (or as a c	consequence of):					
8760,	cate be executed ohysician and the burial-transit	lica		J						
9	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE:							
P.O. Box	th ce	an/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth 2	Fetal death 3	□Ectopic pregnancy			23d. Date of deliver	ery Day Year
E	e dea	Sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tir 9□ Unknown	me of death 5	Other (specify)				
<u>م</u>	that the de led by the a detached f	Phy	Part II. Other significent conditions con	ntributing to death but	not resulting in the	underlying cause give	en in Part I	23e. Did tob	acco use contribute to t	he cause of death?
Ś	res tha igned I be det	by	Part II. Other significent conditions con	tributing to death but	not resulting in the	underlying cause give	arrier arct.			pably 4 □Unknown
0	w requir been si should	sted								
ec	law lasb	du						24a. Was an autopsy perform	prior to co	opsy findings available impletion of cause of
<u> </u>	The page	Completed							XNo 1 ☐ Yes	2□ No
/ita	sician: The law s certificate has b lirector, page 2 s	Be	25. Was case referred to medical examiner?	Inneital:		Oth	200	h (Check only one		
<u></u>	hysi this c	ပ္	I Tes 2 X No	Hospital: 1 Anpatient			4 L Nuising 11		nce 6 Other (Special	fy)
Division of Vital Records,	Attending Physician: or death. ector: After this certification by the funeral director.	Certification:	27. Manger of Death 1 X Natural 5 □ Pending	28a. Date of Injury (Month, Day)	Year) 28b. Time Injury	Worl	γat ⟨? Yes 2 □ No	28d. Describe how	w injury occurred	
Sio	tend leath tor: / the f	cat	2 Accident investigation 3 Suicide 6 Could not be	Do Diversitation	At home form		195 2 NO	29f Location /Str	eet and Number or Run	al Route Number
\leq	l or Attendate deatl Director:	ii.	4 Homicide determined	building, etc.	(Specify)	street, factory, office		City or Town,		ar 7 (0010 / 1011100),
	urs a urs a aral E		haring his phase and the phase	nining. To the heat of	mu kasuladas, da	oth cooursed at the time	no, data and place	and due to the ca	use(s) and manner as s	tated
	Hos 24 ho Fun Fun	Ca	29a. Certifier Certifying Phy (Check only 2 Medicel Exami	ner: On the basis of e	xamination and/or	investigation, in my of	pinion, death occur	red at the time, da	te and place, and due t	o the cause(s)
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h, completely filled in by the funeral director, page	Medical	29b. Signature and title of certifier	and mainly state		29c. License	e number	29	d. Date signed (Month,	Day, Year)
ì	2 ± ₹ 00			A +	e ₁	D	48098		1/9/20	06
	1.			ampleted cours of de-	ath /itam 32=\ /T-		102 10		1 . 1 - 0	- (-
	10		30. Name and address of person who co				hrrarr C	ricfic12	מוסוכ תא	
	Sta	to	Vijay Karumb 31. Date filed (Month, Day, Year)	37 Registrar	s Signature	r nait nio	ilway - C.	ristieia	1 LID 2101/	
	Regist		JAN 1 3 200	6 Same	s Signature	out.				

		Please	Type or Print in E							006	nΙ
		For	State of Marylan				lental Hy	giene	UUO	000	Ui
		1 - State Registrar		Ce	rtificate of	Death		Reg. No.			
Physical	31	Decedent's Name (First, Middle, La	ast)				2. Date of Dea Month	Day			
Physicia /Medic		JEROME		S	HERMAN		JANUAR'		2006	8:32	A M
Examine		4a. Facility Name (If not institution, given	ve street and number)			or Location of Death		4c.	County of Dea		
		SINAI HOSPITAL				BALTIMORE				N/A	
Funeral Director		052-16-7763	Sex 7. Age (In yrs. I	last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt Month, Da MAY 6,	1916	9. Bi	rthplace (State of Country)	_
pu k		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y. Town or Lo	ocation					10d. fnside C	ity Limits
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Iteme 23s or 28s-f ehow eumatic event, it a Mudical Evantural must be notified at	ţō	MD	N/A		IMORE					1 🙀 Yes	2 □ No
1 the	al Director	10e. Street and Number			10f. Zip Code			10g. Citi	zen of What C	country?	
38 o		7121 PARK HEIGH	ITS AVENUE			21215			USA		
death me 2	era	11. Marital Status	12. Was Decedent Ever in U.	.S. 13.	Was Decedent of H	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No	-	14. Race - Am		
r Ite	by Funerai	1 Never Married 2 Married	Armed Forces? 1 X Yes 2 ☐ No		1 ☐ Yes 2 X No		rican, etc.)		Black, Wh		=
urs a		3 X Widowed 4 □ Divorced	ff Yes, Give Year or Dates:		1 U Yes 2 IA No	Specify:			Specify:	WHITE	
2 ho	Completed	15. Decedent's E		16a. Dece	dent's Usual Occup	oation during most of work	ina	16b. K	nd of Busines	s/Industry	
hin 7	pje	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)					
od wil	5		5+	PHYS	SICIAN	·			DICAL		
at Hy	Be (17. Father's Name (First, Middle, Las	t)			18. Mother's Nam		Maiden	Sumame)	04001	- D
Ment Ment	ဂ္	ISAAC		SHER		PAULIN				GARBE	:K
and and is my		19a. Informant's Name/Relationship				and Number or Rur					
and ealth m 27		HOWARD ROSENBLA				IA ROAD #					
		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 [Removal from State	emetery, cre	osition (Name of matory or other pla	cө)	Date		cation - City o		
Pages nent of I ent: If it ury or o		4 Donation 5 Other (Special	ify) BAL	TIMORE	HEBREW	CEM. 01/1	2/2006	R	EISTER:	STOWN, N	1D
permit. Deperti Import any Inj once.		21. Signature of Funeral Service Lice	ensee	2:	2. Name and Addre	ess of Facility SOI	LEVINS	SON	& BROS	, INC.	
80 5 5 6		notes)	d-			TERSTOWN			SVILLE	MD 212	208
	_	23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused the death one cause on each line.	h. Do not en	ter the mode of dyin	ng, such as cardiac	or respiratory ar	rrest,		Approximation finterval Bet	ween
Physician		Immediate Cause (Final disease or condition	Deputies	000	none					Onset and	Death
/Medical		resulting in death)	Due to (or as a consequence	_						1 435	
Examiner		I	. cerebra	Varial	lor cuide	4.4				10-12	E 13
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence								
cuted	aminer	Cause (Disease or injury that initiated events	c								
exection and and and and and and and and and an	Exa	resulting in death) Last	Due to (or as a consequence	uence of):							
e be /sicie e bur		(d								
g phy as th	edi										
ondin use	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		⊒Ectopic pregnanc				23d. Date of d		
deatl	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of d		Other (specify)	7			Month	Day	Year
t the by th ache	hys	9 Unknown	9 Unknown								
s tha	y P	Part fl. Other significant conditions		-	underlying cause giv	ven in Part I.	23e. Did to	obacco u	ise contribute	to the cause of	teath?
quire n sig uld b	ed E	coro	nors when dixex				101	res 2	™ No 3□F	robably 4 🗆	Unknown
s bee	let						24a. Was	an	24b. Were a	utopsy findings	available
hystcien: The law requires that the death certificate be executed his certificete has been signed by the ettending physicien and it director, page 2 should be detached for use as the burral-transit	Completed						perfo	prior to completion of cause of death? ses 2 No 1 Yes 2 No			
ifficet or, pe	ပိ	25. Was case referred to medical		· · · · · · · · · · · · · · · · · · ·		26. Place of Deat			1016	3 Z NO	
s cert irect	o Be	examiner?	Hospitaf: 1 ☐ Inpatient 2 💢	ER/Quinatie	nt 3 DOA Ott	her: 4 Nursing Ho			6 Other /Sn	ecify)	
\$ # B	F		inpution 2 th	Catpatio	J_ JOA		0				

Examine To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the buriar-transit Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? fnjury 5 Pending investigation 1 Yes 2 No М 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29c. License number

D20604

9

Medical Certification:

30. Name and address experson who completed cause of death (Item 23a) (Type, Print) # 450; 10755 Fells A); Latheral & 21093

10Bc

29d. Date signed (Month, Day, Year)

1/10/06

State Registrar. 31. Date filed (Month, Day, Year)

JAN 1 3 2006

29b. Signature and title of certifier



7.20

			1- For State of Maryland / Depa	rtment of Health and M tificate of Death	lental Hygie	/ HIII					
	Physici		1. Decedent's Name (First, Middle, Last) TO AN TEBA	Y	2. Date of Death Month	Day Year 7.13 A M					
i	/Medic Examin		4a. Pacility Name (If not institution, give street and number) LAUREL REGIONAL HOSPITAL	4b. City, Town, or Location of Death LAUREL		4c. County of Death PRINCE GEORGE'S					
	Funeral Director		5. Social Security Number 529-44-5356 6. Sex 1 □ M 2 ☑ F 7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, You Jan 2, 1	9. Birthplace (State or Foreign Country)					
	e Maryland ta-f ehow	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	ation		10d. Inside City Limits 1 ☐ Yes 2 ☒ No					
	with th	Dire	10e. Street and Number	10f. Zip Code		. Citizen of What Country?					
036	filed within 72 hours efter death with the Maryland Hygiene. ther then "natural", or items 23a or 28s-f ehow ther, the Madical Exacilmet cust be multified at	by Funeral Director	1 Never Married 2 Married 1 Yes 2 XNo	20708 Vas Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto □ □ Yes 2 ☑ No Specify:		J.S.A. 14. Race - American Indian, Black, White, etc. Specify: White					
21215-0036	be filed within 72 hours tal Hygiene. d other then "natural", event, I're Medical Exp	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 16a. Deced (Give k lifts. D Homem	ent's Usual Occupation kind of work done during most of workin O NOT use retired)	ng	b. Kind of Business/Industry					
	m - 0 5	Be Co	17. Father's Name (First, Middle, Last)		(First, Middle, Mai						
Maryland		Jo.	Earl Francis Martin Derrick	Edna Rev							
Nar	d 2 s th arr			g Address <i>(Street and Number or Rur</i> a Thistlewood Terra		onsville, MD 20866					
Baltimore,	Pages 1 and nent of Health ent: if item 27 ary or other tr		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ Removal from State 20b. Place of Disposicementary, crem		Date 200	c. Location - City or Town, State					
Baltir	permit. Pages 1 and Department of Healt Importent: If Item 2 any injury or other once.		21 Signature of Fuseral Service Licensee / 22	Name and Address of Facility		ryland 20707-4389					
THE PERSON NAMED IN	Physician /Medical Examiner	-	23a. Part I. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, it have it filture. List only one cause on each line. Immediate Cause () read disease or condition resulting in death) a								
68/60,	certificate be executed nding physicien and use as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury) that initiated events resulting in death) Last c	y ACKALO	875	2442					
O. Box t	death e atter	Physician/Me		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year					
ecords, P	law requires that the de es been signed by the a 2 should be detached i	by	Part II. Other significant conditions contributing to death but not resulting in the uncompanied of the significant conditions contributing to death but not resulting in the uncompanied of the significant conditions contributing to death but not resulting in the uncompanied of the significant conditions contributing to death but not resulting in the uncompanied of the significant conditions contributing to death but not resulting in the uncompanied of the significant conditions contributing to death but not resulting in the uncompanied of the significant conditions contributing to death but not resulting in the uncompanied of the significant conditions contributing to death but not resulting in the uncompanied of the significant conditions contributing to death but not resulting in the uncompanied of the significant conditions contributing to death but not resulting in the uncompanied of the significant conditions contributing to death but not resulting to the significant conditions contributed on the significant conditions conditions conditions conditions conditi	derlying cause given in Part I.	23e. Did tobac 1 ☐ Yes	co use contribute to the cause of death?					
r	The te h	Completed	Schikophvema		24a. Was an autopsy performed						
VII	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death							
on of	ng Phys fter this meral di	tlon: To	1 Yes 2 No Postient 2 ER/Outpatient 2 ER/Outpatient 2 Natural 5 Pending (Month, Day Year) 28b. Time of Injury (Month, Day Year) 28b. Time of Injury (Month, Day Year)	3 DOA 4 Indising Hon	me 5 ☐ Residence 28d. Describe how i	e 6 \(\text{Other (Specify)} \) injury occurred					
Division	el or Attending s efter death. I Director: After d in by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, streed building, etc. (Specify)	et, factory, office	28f. Location (Stree City or Town, S	it and Number or Rural Route Number, Itate)					
	To the Hospitel or Attendi within 24 hours efter death. To the Funerel Director: A completely filled in by the fu	edicai	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner On the basis of examination and/or inventor one) 2 medical Examiner On the basis of examination and/or inventor one)	occurred at the time, date and place, a estigation, in my opinion, death occurre	and due to the caus ed at the time, date	e(s) and manner as stated. and place, and due to the cause(s)					
	with Com	Σ-	290. Signature od title of certifier M)	29c. License number	25Z 29d.	Date signed (Month, Day, Year)					
	15		30 Name and address of person who concluded cause of death (Item 23a) (Type, FROMENTO ADEACTRILLY) 14300 GM	CLANT FOX LA	#1228	WIEND20715					
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 1 3 2006	1340							

			For State Registrar	State of Ma		-		t of H	ealth	and M	lental Hy	giene	006	00603
			Hegistrar Decedent's Name (First, Middle,)	Last)							2. Date of De	ath		3. Time of Death
	Physici		Leander	H Thur	ma	N					Januar Januar	Day	200	0 130 PM
	/Medic Examin		4a. Facility Name (If not institution, g				4b. City,	Town, or	Location	of Death	(/ 4c.	County of Dea	th
	LXamin	٠.	Genesis Home w	ood Nursing	Fag.	liter	Be	eltir	nove				NA	1
	Funeral		5. Social Security Number 6	. Sex 7. Ag	e (In yrs. I	last birthday)	If Under Months			r 24 Hrs. Min.	8. Date of Bir (Month, Da 5-9	th av. Year)	9. Bir	thplace (State or Foreign ountry)
	Director		267-40-6278	1X M 2□ F	74	Yrs.					5-9	-31		Fla.
	pu ≱	}	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside City Limits
	anyla shov	٦			100.00		sby							1 ☐ Yes 2 No
	Sa-f	Director	Md. Cal	vert		ьu	10f. Zip	Code				10g. Citi:	zen of What C	ountry?
	a or	급		***			102.0	206	557				USA	,
	eath	Funeral	4020 Lake Dri	12. Was Decedent	Ever in U.	S. 13.	Was Deced			rigin? (Spe	ecify Yes or No Rican, etc.))- ·	14. Race - Am	
10	r iten	Fu	1 ☐ Never Married 2 ☐ Married	Armed Forces?		ł					Rican, etc.)	1	Black, Whi	
036	hours after death with the Maryland tural; or Items 23a or 28a-f show at Evantiner must be rrutified at	b	3X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes :	ZZ No	Specify	/: 			Specify:	Black
ည	J within 72 hours after death with the Marylan plene. r then "netural; or liems 23a or 28a-f show the Masical Examinat must be ruithed at	Completed	15. Decedent's (Specify only highest			16a. Dece	dent's Usua kind of wor	al Occupa rk done d	ation during mo	st of worki	ing	16b. Kir	nd of Business	/Industry
2	within 72 ene. then "ner	nple	Elementary/Secondary (0-12)	College (1-4or	5+)		DO NOT us)			Post	thlehen	Stool
21	s filed withi I Hygiene. other then		7th grade			<u> </u>	abore	er.	10 Moth	ore Name	(First, Middle	1		Dreet
E D	be de la la la la la la la la la la la la la	Be	17. Father's Name (First, Middle, La Johnnie	ist)		Thur	man		TO. MOU		zabeth			ger
ž	d 2 should by and Mente 7 is marked treumatic e	ပ္	19a. Informant's Name/Relationship	(Type Print)				(Street a	and Numb	oer or Rura	i Route Numb	er. City or		Zip Code)21202
Maryland 21215-0036	12 th ar		Herger Thurman		her	l .					Apt.			more, Md.
ē,	s 1 and 3 f Health item 27 other tr		20a. Method of Disposition		20b. P	lace of Dispo	sition (Nan	ne of	(a)		Date	20c. Lo	cation - City or	Town, State
Baltimore,	e = 5		1 Burial 2 Cremation 3 4 Donation 5 Other (Spe			Trini	-	-	1	1-17	7-06	Dur	ndalk,	Md.
Ħ	permit. Par Departmen Important: any injury		21. Signature of Funeral Service Li				2. Name an		s ol Facil				e, Md.	21202
ä	Depa Impo impo any i		Drafton Mil	March F.H. East 1101 E. North Ave.										
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between
	Physician		onset and Death Mediate Cause (Final Jung Cancer Jung Cancer											Onset and Death
	/Medical Examiner		Due to (or as a consequence of):											
١.	34	-	Sequentially list conditions,	b. Due to (or as	а сопѕед	uence of):							-	
H	nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			,								
<u> </u>	te be executed ysician and se burial-transit	Examiner	resulting in death) Last	C Due to (or as	a consequ	uence of):								
760,	± % €	cai		d										
99	ng ph	Med	IF FEMALE:											
Вох	eath certifica attending plant for use as t	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Feta	I death 3	Ectopic pr					2	23d. Date of de Month	livery Day Year
о. В	at the dea by the a tached fo	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□ Unknown	t time of de	eath 5∟	Other (sp	ecity)			*			
Ω_	that the		Part II. Other significant condition	s contributing to death b	out not resi	ulting in the u	nderlying c	ause give	en in Part	1.	23e. Did t	tobacco u	se contribute t	o the cause of death?
Records,	8 5 9	d by					_				10	Yes 2	□No 3□P	robably 4 Striknown
COL	w require been si should b	Completed									24a. Was		24b. Were a	utopsy findings available
Re	The lav	duo									auto perfo	psy ormed? 2 X No	death?	completion of cause of
Vital		(a)	25. Was case relerred to medical						26. Plac	e of Death	(Check only o			
Σ	S S	To B	examiner?	Hospital: 1 Inpati	ent 2	ER/Outpatier	nt 3 DC	Oth	er: 42 N	Lursing Ho	me 5□Resi	dence 6	S □Other (Spe	ecify)
n of			27. Manner of Death Natural 5 □ Pending	28a. Date of Inju (Month, Da	iry ly Year)	28b. Time of Injury		8c. Injury Work			28d. Describe	how injury	y occurred	
Sio	Attending ir death. ector: After by the fune	cati	2 Accident investiga 3 Suicide 6 Could no	t bo			М		Yes 2		20(1	Chandan	d Museban on C	hard Davida Marahas
Division	D it to	Certification:	4 Homicide determin		jury - At ho tc. <i>(Specif</i>)	ome, farm, str y)	reet, lactory	y, office			City or To			ural Route Number,
ш	pitel		29a. Certifier Certifying	Physicien: To the best	of my kno	wledge, deat	h occurred	at the tin	ne. date a	ind place,	and due to the	cause(s)	and manner a	s stated.
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical		caminer: On the basis of and manner st	of examina									
	To the within To the comp	Me	29b. Signature and title of certifier				290		e number				e signed (Mon	
			1 Andra		1				0005	5942.	5	Janu	ery 10	2006
	2		30. Name and address of person w	ho-completed cause of				0.0	. ^	41		\ _		2006
	~ 1			oval Samuri	tren) 1	Hospitz	eltro	F 13	uilde	nog	303 13	restriv	more r	47 51238
920	Sta		31. Date filed (Month, Day, Year)	32. Regist	ars Signa	uture)				
	Registi	aı	IAN 1 2 20	nc la	16	La	K.							

DHMH 17 Rev 1/2001

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vibett Dovoth

			For State Registrar	State of Ma	-	epartme C <i>ertifica</i>					giene Reg. No.	006	0061	15
	Physicia		1. Decedent's Name (First, Middle, La RUTH C. THOMS							Date of De Month	Day	Year	3. Time of 0	Death PM
	/Medic Examin		4a. Facility Name (If not institution, give	re street and number)			,	r Location		1_15_		ounty of Death		
			JOSEPH RHCHIE 5. Social Security Number 6. S	HOSPICE	(In yrs. last birtho		der 1 Year	RE If Under	24 Hrs. 9	Date of Bir	th	N A	place (State or	Foreign
	Funeral Director				59 Yr	Month		Hours	Min.	Date of Bir (Month, Da 2.12.	1946	Cou	mtry) MD	
	yland		10a. State 10b. County		10c. City, Town	or Location							10d. Inside City	
	ith the Marylan or 28a-f ehow	ctor	MO BALTIM	ORE	GWYN	N DA	K						1 🗌 Yes	2 🛛 No
	with th	Dire	10e. Street and Number	1 0100		10f.	Zip Code	7			10g. Citize	en of What Cou	ntry?	
	eath v	erai	6553 WOODGREEN 11. Marital Status	12. Was Decedent E	ver in U.S.	13. Was De	2120		igin? (Specif	v Yes or No)- 1e	USA 4. Race - Ameri	can Indian.	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23a or 28a-f show eny injury or other treumatic event, the Medical Exactinat must be notified at once.	by Funerai Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1 Yes 2 No. If Yes, Give Year or Dates:			specify Cuba		igin? (Specif n, Puerto Rid :	an, etc.)		Black, White		
0-0	72 hou	ted	15. Decedent's E	ducation	16a. D	ecedent's U	Isual Occup	nation	st of working		16b. Kin	d of Business/Ir		
Baltimore, Maryland 21215-0036	ithin 7 ne. hen "r	Completed by	Elementary/Secondary (0-12)	College (1-4or 5-	-1 .			d)	st of working		11.5	GOVERA	LONGATI	
12	iled w Hygier ther ti	S	12 TH GRADE 17. Father's Name (First, Middle, Last	N/A	1	RINTE	≈K	18. Moth	er's Name (F	irst. Middle			MEINI	
and	id be entat ked o	To Be	LEWIS PEALS	,					ORED			106		
ary	shou and M s mer	-	19a. Informant's Name/Relationship	(Type, Print)	19b. N	Aailing Addre	ess (Street					Town, State, Zi	p Code)	
Σ	and 2 Balth a n 27 t		ROBERT THOMPSI	ON (HUSBAI		A STATE OF THE PARTY OF THE PAR	DODGR	EEN	CIRCLI		170.1		07	
ore	ges 1 t of H if iter or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 [crematory o	Name of or other pla		Date			ation - City or T		
i i	it. Paritmen rtant: njury		4 □ Donation 5 □ Other (Special Service Lice		KING F	22 Name	and Addre	see of Engili	01.17.0			ALLSTON	UN N	ND
Ba	permi Depe Impo eny ir		Vansh C			VAUGH	N G. G	REFINE	FUNER			<i>9</i> a		
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused	the death. Do no								Approximate Interval Betw	veen
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ords,	w requires thet the death cert been signed by the attendin should be detached for use ?	Ď	Fait ii. Other significant conditions	Contributing to death of	criot resulting in t	ne unuenyin	ig cause gn	veil el Fait				No 3□Pro		Ínknown
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201	ding Phys h. After this funeral di	n: To	27. Manner of Death	28a. Date of Injur (Month, Day	y 28b. Tir		28c. Inju			d. Describe			3) 110 400	<u> </u>
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Ruth Thomy Division of Vika	To the Hospital or Attanwithin 24 hours after deall To the Funeral Directors completely filled in by the	Medicai		miner: On the basis of and manner sta	examination and/									1
	To the Within To the Comp	Σ	29b. Signature and title of certifier				29c. Licens	se number			29d. Date	signed (Month	, Dey, Year)	
	1		Stirlliam Ben				Do	20-82.	83		1/4	06		
	6		30. Name and address of person who				210			2.4415				
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	a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Md. Balt	imore	10c. Cit	y, Town or Lo	cation s Mill	ls			-			10d. Inside City Limits 1 ☐ Yes 2 ▓ No			
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036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene importent: If Item 27 is marked other then "neturel; or Items 23a or 28a-f show any injury or other traumetic event, the Medical Eracid at must ke notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 🛣 Mar 3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Forces ried 1 X es 2 If Yes, Give Year or Dates	s?]No WW	1 1	Was Decede	er.	spanic Origin, Mexican Specify:	gin? (Spe i, Puerto	cify Yes or No Rican, etc.)	E	Race - Ameri Black, White, acity: Whi	etc.			
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Baltimore,	Pages 1 a lent of He nt; If item ry or other		20a. Method of Disposition 1 🖾 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5			Place of Disponentery, creating preen					14,200		0.				
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		Registrer Certificate of Death	2. Date of Death	No. O O O	3. Time of Death
Physicia	an	1. Decedent's Name (First, Middle, Last) Ellen Marie Tate	Month	Day Year	0046 M
/Medic		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	01 0	4c. County of Dea	
Examin	er	Para lace (Parisonal and ical Cartee Solich Ical		Wicom	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye		thplace (State or Foreign
Funeral: Director		202-26-1210 1 M 2 M F 69 Yrs. Months Days Hours Min.	10-19-19	936	PA
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anylan show	_	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☐ Yes 2 No
8a-1	5	MD Worcester Ocean City			
be filed within 72 hours after death with the Maryland tall Hygiene. I hours after death with the Maryland of other than "natural", or items 23a or 28a-f show event, it a Modical Examinar must be notified at	Funeral Director	10e. Street and Number 10f. Zip Code		Citizen of What Co	ountry?
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urs af	by	If Yes, Give 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		Specify: Wh	ite
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thin 7 8.	ple	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) (Give kind of work done during most of working life. DO NOT use retired)	''y		
og will	Completed	4 Teacher		Educati	on
be fill tal Hy d oth	Be		e (First, Middle, Mai		
should and Men	ပ		ret Harki		T. O
2 sh and Is m		19a. Informant's Name/Relationship (Type, Print) Mrs. Mary M. Lyons / Daughter 1505 Gollum Road; Hand			Zip Code)
permit. Pages 1 and 2 should be filed within 72 h Copartment of Health and Mental Hygene. Important: If Item 27 is marked other than "naturent sny injury or other traumatic event, the Modical Anne.				. Location - City or	Town, State
Pages nerí of int: If It		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State			
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80		23a, Part1, Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of			Approximate
Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	~4		Interval Between Onset and Death
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tendi leath. for: A the fu	catl	2 Accident investigation M 1 Yes 2 No			
l or Attend after death Director: /	Certification:	3 Suicide 4 Homicide 3 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S		urai Houte Number,
pital		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	and due to the caus	a/s) and manner a	s stated
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: An order that been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	ed at the time, date	and place, and du	to the cause(s)
o the	Me	29b. Signature and title of certifier 29c. License number	29d.	Date signed (Mon	th, Day, Year)
->= 0		D057359		Jan-812 3	2006
/		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			
15		DR-USHA NATESAN 1415. S. DIVISION ST, SALISBURY	M) 218	04	
Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature		1	
Registr	ar	JAN 1 3 2006 Breve & Sparker			

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Per FH G851 1 Certificate of Death State Regist<u>Amend</u> Reg. No. item 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician Marsha Lynn Turriff 9:00 a. January 6, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ellicott City Howard 3005 Woodberry Lane If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, 20, Apr 20, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Days **Funeral** Hours 1 ☐ M 2 및 F Yrs. Director 305-66-7446 Indiana Usual Residence of Decedent 10c. City, Town or Location the Maryland 10d. Inside City Limits 10b. County 10a State ral', or itams 23a or 28a-f show Examiner must be rutified at 1 ☐ Yes 2 No Ellicott City Howard Maryland Maryland Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21042 USA 3005 Woodberry Lane Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?, l ☐ Yes 2 😿 If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: ğ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 7 is marked other than "natu traumatic avant, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Banking Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Realty Assistant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mental is markad o Lula Mae Street 2 Walter L Wilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a important: if itam 27 is any injury or othar tra once. 3005 Woodberry Lane Ellicott City, Maryland 21042 Mr Arthur E Turriff Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) 01/12/2006 Ellicott City, MD St. John's Cemetery 22. Name and Address of Facility natur of Funeral Service Licensee Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043
23a. Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) yen Physician IZAS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 Probably 4 □Unknown funeral director, page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 ☐ Yes 2 ☐ No 1 Yes 2 **/**10 Hospital or Attanding Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner Other: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home sidence 6 ☐Other (Specify) Certification; To 1 🗌 Yes shis 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of 27. Manner of Death After 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide determined filled in by 4 | Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely To tha I within 2 To tha 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 006 ed cause of death (Item 23a) (Type, Print) 30. Name and address of person who com 301 Schen

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Registrar

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2006

31. Date filed (Month, Day, Year)

32, Registrar's Signature

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Amend item#9, perFH, C851, 1/13/06 TT
State of Maryland / Department of Health and Mental Hygiene
Amend item#4c, 9, perFH, MD, C851, 1/13/06 TT
Certificate of Death
Reg. No. 1 - For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month PM **Physician** PHIBI von HAUS SKNAMAL 900P /Medical 4c. County of Death Baltimore 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner OAK! RSST ARI VER II Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1□ M 250 F Months Days Hours Yrs. 30 Usual Residence of Decedent Director 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f ehow the Medical Examiner must be cottilled at 1 ☐ Yes 2 No Directo AROSY BALLinor C)ACYLAW 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ŏ 21234 V.S.A. #332 23a BLVO-3839 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-Il Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Marned 1 ☐ Yes 25 No Specify. WHILE 21215-0036 ö Specify: þ 3X Widowed 4 □ Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) HOSPITA! 3795 1.97487 other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Maryland Be ie marked of SUTPHIN HASAG KOBERT ARSHALL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2. Iment of Health a tant: If item 27 is 070975000 K. DRIVE AND 26021 20X31 MILLIM Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5 permit. Page Department of Important: If any injury or once. MARRIOTEVIUE MARRADO □Donation 5 □ Other (Specify) WE RE 3000 21. signature of Funeral Service Licensee 22. Name and Address of Facility () In () () 32 21234 ARKVILL MARYLAND do CADY CHOLINAK GOBB 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on early ne. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed Due to (or as a consequence of) 68760, by Physician/Medical The law requires that the death certificate Box 23c. If yes, outcome of pregnancy 23d. Date of deliven 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months
1 Tyes 2 TNo Month Day Year 4☐Pregnant at time of death 5 Other (specify) Ö 9 Unknown 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably Junknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death [Check only one] Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 2 ☑ No 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b Time of 28c. Injury at Work? 27. Manner of Death Division To the Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident after death the 6 Could not be 3 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) filled in by 4 Thomicide within 24 hours a

To the Funeral E

completely filled 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number ress of person who completed cause of death (Item 23a) (Type, Print) 8800 Walther Bird. BALTIMONE w Houce 2005 32. Registrar's Signature 31. Date filed (Month, Day Ye State Registrar

100 Hagel

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 2006 Leroy Allen Windsor January 11, /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 8001 Stone Haven Drive Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 63 Yrs. Director 219-38-1846 11/11/1942 MD Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County ir then "natural", or itema 23a or 28a-f ehovite Medical Examinar must be nutified at 1 Yes 2 Ne Director MD Glen Burnie Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8001 Stone Haven Drive 21061 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. hours after 1 Yes 2 No 1 Never Married 25 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 Yes 2 Specify: Specify: White þ 1966 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Calvert Distillery e filed within 7 al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Maintenance 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be f and Mental H Leroy Allen Windsor Marion Eliziver Vanskiver ie marked 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Depertment of Heelth are Important: If Itam 27 is eny injury or other trau Pages 1 end 2 Margaret Windsor/Wife 8001 Stone Haven Drive Glen Burnie, MD 21061 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Jan 13 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2006 Beltsville, Maryland Chesapeake Crematory 22. Name and Address of Facility
Cremation and Funeral Alternatives 21. Signature of Funeral Service Licensee Rattes 8717 Green Pastures Drive Baltimore, Maryland -MO144 23a. Part1. Onter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Chronic **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physicien and d be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown bluods Completed 24a. Was an autopsy performed 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has b of Vital 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 EN/Outpatient 3 DOA 1 Tyes After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. escribe how injury occurred 27. Manner of Death 28b. Time of Medical Certification: 1 Natural
2 Accident Division 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: / 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 | Homicide ŏ within 24 hours a
To the Funeral Completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Nam and ad cause of death (Item 23a) ype, Print) 31. Date filed (Month, Day, Year) strar's Signature State Registrar 7886

		,	For State Registrar	State of Maryland		artment of tificate of		nd Mental Hy	/giene	6 00612
			Decedent's Name (First, Middle, Last)					2. Date of D		3. Time of Death
	Physicia		Edna Ruth Wall	ker				Janua	ry 12, 20	006 10:19 A ^M
	/Medic Examin		4a. Facility Name (If not institution, give si	treet and number)		4b. City, Town,	or Location of	Death	4c. County	
			14909 Wellwood Ro	ad		Silver	Spring	Į.	Monte	gomery
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I. M 2DIF 54	**	If Under 1 Yea Months Days		Min. (Month, D	ay, Year)	Birthplace (State or Foreign Country)
	Director		367-70-9704	M 2121 34	Yrs.			Jan. 1	9, 1951	Mississippi
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Aaryii I sho	5	Maryland Montgome		ver Sp					1 ☐Yes 2 ☐ No
	28a-	ect	10e. Street and Number			10f. Zip Code			10g. Citizen of W	/hat Country?
	With 3e or	۵	14909 Wellwood Road	d		2090	5		United	
	deeth ms 2;	Funeral Director		2. Was Decedent Ever in U.	S. 13. y	Vas Decedent of	Hispanic Origi	in? (Specify Yes or N Puerto Rican, etc.)	o- 14. Race	- American Indian,
20	or iter		1 ☐ Never Married 2∑ Married	Armed Forces? 1 ☐ Yes 2 ☑ No	İ			Puerto Hican, etc.)		k, White, etc.
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2	nthin ne. han	dr	Elementary/Secondary (0-12)	College (1-4or 5+)					Modica	1 Research
2	be filed within 72 hours after deeth with the Maryland Hygiene. Hygiene. do ther than "neturel", or items 23e or 28a-f show do ther than "neturel", or items 23e or 28a-f show event. The Medical Examinar must be notified at	S	17. Father's Name (First, Middle, Last)	4	Reg1	stered		s Name (First, Middle		
anc		Be	Unknown					erta Winsl		θ)
Ž	should be ind Mental s marked o umatic eve	င္	19a. Informant's Name/Relationship (Typ	ne Print)	19h Mailin	n Address (Stree		or Rural Route Numi		State Zin Code)
Ξ	d 2 th a tre		Elijah Walker/ Hus					Silver S		
a)	s 1 end I Health Item 27 other tr		20a. Method of Disposition	20b. Pl	ace of Dispo	sition (Name of	(aca) T=	anuary 28	20c. Location -	City or Town, State
E 0	permit. Pages Department of i importent: If its any injury or o once.		¹X☐ Burial 2 ☐ Cremation 3 ☐ Re ¹ 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Tru	evine rch Ce	Baptist emetery	ace) [0 2	2006	Brandon	, MS
ati	mit. partm sorte / inju		31. Signatur) of Fune : I Servic : Cicense		22	. Name and Add	ress of Facility			Funeral Home
n	8 9 E 8 8		JERME!	also	15	525 Beas	ley Roa	ad, Jackso	n, MS 3	9206
l			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death	. Do not ente	er the mode of dy	ing, such as c	ardiac or respiratory	arrest,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	BREAST (3 ANC	ER				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	7-77-7					
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89	rtifica ng ph as th		IS SCHALE.							
ŏ	eath certific attending p	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	ic. If yes, outcome of pregnate 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnan	су		23d. Date Mon	e of delivery oth Day Year
O. B	e dea the at ned fo	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of de 9 Unknown	eath 5□	Other (specify)			IVIO	an Day Teal
<u>.</u>	res that the de signed by the a be detached f		Part II. Other significant conditions conf	tributing to death but not resu	ulting in the ur	nderlying cause o	iven in Part I	23a. Did	tobacco use contri	ibute to the cause of death?
Records,	The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	d by		3	g	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,	1 🗆	Yes 2 No	3 ☐ Probably 4 ☐Unknown
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0	Attending I death. ctor: After y the funer	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,		Yes 2 □ N	0		
Division of	i or Atten after deat Director: I in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, larm, str	eet, lactory, office	9		(Street and Numbe wn, State)	er or Rural Route Number,
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	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certification in the Funerel Director: After this certification in by the funeral director.	edical		ician: To the best of my knowner: On the basis of examinat and manner stated.						
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	.7		30. Name and address of person who opi				27	30 UNIV	ERSITY E	GOV STILLS. CVIE
			CHERYL A				wi	HEATON, I	MD 208	02 3110. Suite 400 317
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	Registr	ar	1AN 1 3 200	O MARINE S	14	33				

			1 - For State Registrar	State of Ma	ıryland /		irtmen <i>tificate</i>					jierje og. Ño.	006	006	13
	Physici	20	Decedent's Name (First, Middle, L								2. Date of Dea Month	th Day	Year	3. Time of	Death
	/Medi		Alvina Theresa Wal								January 10	4	2006	10:05	Рм
	Examir	ier	4a. Facility Name (If not institution, g. 8808 Walden Court A	pt # 1202				kvill	le			Ba	County of Death		
	Funeral Director		213-18-6959	Sex 1□ M 2 F 7. Age 1 R 86	(in yrs. last t	Yrs.	If Under Months	Days	Hours	Min.	8. Date of Birth (Month, Day Arch 25,	1919	9. Birth Cou Balt	place (State on ntry) imore, N	nr Foreign
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation							10d. Inside Ci	ty Limits
	Mary 1 sh	to	Maryland Balti	more		Parkv	/ille							1 □Yes	2 X No
	or 28s	Director	10e. Street and Number				10f. Zip	Code			1	0g. Citiz	en of What Cou	ntry?	
	ath wi	rai	8808 Walden Court Ap					L234					ited Stat		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 le marked other than "natural", or Itame 23a or 28a-f show hipportant: If Item 27 le marked other than "natural", or Itame 23a or 28a-f show any injury or other traumatic event, the Medical Evantinal matter missible and once.	Completed by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates:		11	Vas Deced fYes, spec I□Yes 2	offy Cubar	spanic Oi n, Mexica Specify	ın, Puerto i	crfy Yes or No- Rican, etc.)		4. Race - Ameri Black, White Specify: Whi	etc.	
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2121	d within 7 giene. ir than "r	ompie	Elementary/Secondary (0-12) 12 Years	College (1-4or 5	+)	life. C	emplo	se retired)) -	St Of WORK	<i>'</i> 9	Groce	ery Store		
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	and 2 should saith and Men n 27 le marke iar traumatic	ď	19a Informant's Name/Relationship P. Norman Walls - S	(Type, Print) ON	19		g Address 3 Lee	,			^{(Route Number}	. ,		o Code)	
ore,	of Hee		20a. Method of Disposition	Damauni from State	20b. Place cemet	of Dispos	sition (Nan	ne of ther place	9)	D	ate	20c. Loc	ation - City or T	own, State	
<u>E</u>	Pages ment of I ant: If Its ury or o		1 Burial 2 Cremation 3 4 Donation 5 XOther (Spec	ins) Entombrent	Parkwo		metery	,	l	01/13/			/ille, Mai	ryland	
Baltimore,	permit. Page Department Important: II any injury o		21. Signature of Fundamental Project Lice			Leo	nard J	. Ruc	k, In	c. B	305 Harfo kaltimore,	Mary		214	
Je.	Physician /Medical		23a. Part 1. Enter the disease or loo shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	mplications that caused y one cause on each lin a	Rdie	€ 1	or the mod	4 . 1	n, such as	s cardiac o	r respiratory arr	est,		Approximat Interval Bet Onset and I	ween
8760,	cate be executed physicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a Due to (or as a		e of).									
P.O. Box 6	The law requires that the death certific ate hes been signed by the attending page 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal dea		Ectopic pro					23	3d. Date of deliv Month	•	Year .
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Divisio	To the Hospital or Attending Physiclan: The law within 24 hours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	Certification:	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be Rises of Inju	iry - At home, . (Specify)	farm, stre	M eet, factory		∕es 2□		28f. Location (Si City or Town		Number or Rur	al Route Num	ber,
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		•	State of Maryland / Department of Health and M 1- State Registrer Amend Item #6 Per FH g851 1 Priving type f Death 1- Decedent's Name (First Middle Last)		ene .2.005	00614
П			1. Decedent's Name (First, Middle, Last)	2. Date of Death)	3. Time of Death
	Physicia /Medic		CONSTANCE C. WELCH	January		3:00 a M
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Holy Cross Hospital Silver Spring		4c. County of Death	
_			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8 Date of Birth	Montgome	nplace (State or Foreign
	Funeral Director		577-40-9699 1 Months Days Hours Min.	8. Date of Birth (Month, Day, March 1	Year) Co	Maryland
			Usual Residence of Decedent	TIGHT OF T	J, 1354	laryrana
	yland		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Mar 9-f et	tor	MD Montgomery Rockville			1 ☐ Yes 2 ☐ No XX
	or 28	lrec	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Co	untry?
	within 72 hours after deeth with the Maryland ene. than "neturel; or iteme 23a or 28e-f ehow itan walgal Examina the notified at	by Funeral Director	16520 George Washington Drive 20853		U.S.A.	
	dee Tu	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
9	or it	F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2XXNo Specify:			nite
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an	d be ental	To Be	Walter B. Crossan Florence	e Gribbir	ı	
Maryland	is 1 and 2 should be filed within 72 hours after deeth with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "neturel", or iteme 23a or 28e-1 show other traumatic event, its Medical Exatiting mast its inclified at	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rur	al Route Number,	City or Town, State, Z	ip Code)
	nd 2 alth a 27 is r tree		Sheryl Wood / Daughter 10604 White Rock Ct.	Laurel,	Maryland	20723
re,	f Hei		20d. Highligh of Dispersions of Atlanta along	Date 2	0c. Location - City or	Town, State
Ĕ	Pege ent o nt: If ry or		1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) West Arundel Crematory 1,	/9/2006	Odenton, 1	Maryland
Baltimore,	permit. Peges: Department of It important: If ite eny Injury or ot one		21. Signature of Funeral Service Licensee 22 Name and Address of Facility Donald Son Funeral	Home. P.	Α.	
m	Depa Impo eny l	(C. 1)	/ M00770 313 Talbott Avenue			20707
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition Urosetsis			Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of):			
	Examiner		Sequentially list conditions, b. —			
V	od iii	Examiner	if any, leading to immediate Due to (or as a consequence or):			
4	and I-trans	каш	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
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387	phys the	dical	d			
×	certif Iding	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deli	verv
.O. Box	death certifii e attending p od for use as	clar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		Month	Day Year
o.	0 0 0	by Physician/M	9 Unknown			
s, P	s thet ned b	y P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
rds	quires in signe		Chronic Obstructive Pulmonary Disease	1 ☐ Ye	s 2□No 3□Pro	obably 4XXUnknown
S	s been si	plet		24a. Was an	24b. Were au	topsy findings available
Vital Record	nysician: The law requires thet the nis certificete hes been signed by th I director, page 2 should be detach	Completed		autopsy perform 1 Yes 2	ed? death?	completion of cause of
ta		a)		h (Check only one		
>	Physician: this certific ral director,	To B	examiner? 1 Yes 2 Yes 2 Other: 4 Nursing Ho	me 5 Resider	nce 6 Other (Spec	cify)
ı of	<u>a</u> = e		27. Manner of Death 12. Manner of Death 12. Manner of Death 12. Manner of Death 12. Manner of Death 13. Date of Injury 14. Day Year) 15. Time of Injury 16. North, Day Year) 17. Manner of Death 17. Manner of Death 18. Date of Injury 18. Date	28d. Describe how	w injury occurred	
<u>ত</u>	Attending in death. ector: Alter by the fune	atlc	2 Accident investigation M 1 Yes 2 No			
Division	or Atte	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide determined building, etc. (Specify)	28f. Location (Str. City or Town,	eet and Number or Ru State)	ral Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu					
	Hosp 14 hou Fune fely fil	Medical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	and due to the car red at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the Hospital of within 24 hours aff To the Funeral Completely filled in	Mec	one) and manner stated. 29b. Signature and title of certifier 29c. License number	29	d. Date signed (Monti	n, Day, Year)
1	ĕ≆≓ö				-	,
	Λ		30. Name and address of person who completed cades of death (Item 23a) (Type, Print)		January 6,	2006
	8		Alan R. Segal, M.D. 1500 Forest Glen Road Silver Spri	ng, Marv	land 2091	.0
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
	Registi		JAN 1 3 2006 A A Agade &			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [State Ragistrar Amend Item #5 Per FH G852 2/06/06 ate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** JANUARY 10 9:45 A 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner FREDERICK

| H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth Mar. | 6, 1918 FREDERICK FREDERICK MEMORIAL HOSPITAL 9. Birthplace (State or Foreign 5. Social Security Aut 792 7. Age (In yrs. last birthday) Mary Tand 1 ☐ M 25 F 87 217-05-8342 Yrs. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 2 should be itled within 72 now...
2 should be itled within 72 now...
4 and Mental Hygiene | 12 now...
7 is marked other than "natural", or iteme 23s or 28s-f show |
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8 is marked other than "natural", or iteme 23s or 28s-f show |
8 is marked other than "natural", or iteme 23s or 28s 1 ☐ Yes 🎇 No Maryland Frederick Frederick Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 21704 5955 Quinn Orchard Road U.S.A. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 XXVo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes XX No Specify: Specify: White 3 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 11 School Bus Driver Board of Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Herbert L. Derry Edith Hawn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Kathaleen M. Staley, daughter P.O. Box 636, Sonoita, Arziona 85637 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State United Methodist Cemetery Jan. 14, 2006 Clarksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service I censee ²² Keeney and Basford PA Funeral Home M00255 106 East Church St., Frederick, MD 21701 Approximate Interval Between Onset and Death ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a, Part1. Enter the disease, or complication shock, or heart failure. List only one Immediate Cause (Final disease or condition Uremia 2uh resulting in death) Due to (or as a consequence of): 101 Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examin Due to (or as a consequence of) Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown Day Month Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 3 Probably 4 □Unknown 1 🗌 Yes 2 110 Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Ì ŽX No 2 1 Tyes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide

attending physiclen and I for use as the burial-transit death certificate be executed Box 68760. signed by the a P.0. of Vital Records, certificete hes been si rector, page 2 should l funeral director After Division To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun.

Funeral

Director

Maryland 21215-0036

Baltimore,

Pages 1 end 2 s ment of Health an ant: if them 27 is ury or other treu

ortant: if

permit.
Deportr
Imports
any nji

Physician

/Medical

Examiner

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier 1100

31. Date filed (Month, Day, Year)

29c. License number D09689 29d. Date signed (Mgnth, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

rorre

Austin Pearre, M.D., 300 West Ninth Street, Frederick, MD 21701

State Registrar



	** · · ·	 State Registrar Decedent's Name (First, Middle, La 	st)	001	tificate of l	Jeani	2. Date of De	Reg. No. eath Day	Year	3. Time of Death				
Physic /Medi		Melvin Lee	Weather	ringto	n		Januar	4 9 200	06	9:38 AM				
Exami	9	4a. Facility Name (If not institution, give Dorcors Hospital			4b. City, Town, or Lanham	Location of Death		' 4c. County Prince		rge's				
Funeral Director		5. Social Security Number 6. S		ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da March			place (State or Foreign htry) h Carolina				
pus *		Usuaf Residence of Decedent 10a, State 10b, County	10c. City	, Town or Lo	ocation					Od. Inside City Limits				
Maryla	tor	Maryland Prince G	eorge's	Ü	pper Marl	boro				1 ☐ Yes 2Ã No				
th the or 28a	Director	10e. Street and Number		20	10f. Zip Code			10g. Citizen of V		ntry?				
ath wi	ral	5605 South Marwoo	d Blvd. Apt. 10		20772	lispanic Origin? (Sp	ecty Ves or No	U.S		can Indian,				
should be filed within 72 hours after death with the Maryland a Menial Hygiene. marked other then "natural", or Items 23a or 28a-f show mails event, the Medical Examinar mante event, the Medical Examinar must be notified a	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1/ Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Specify	ck, White,					
72 ho	eted	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of work	ing	16b. Kind of B	usiness/ln	dustry				
permit. Pages 1 and 2 should be filed within 72 hours all Department of Health and Mental Hygliene. Important: If item 27 le marked other then "naturel", or any injury or other traumatic event, the Medical Examples.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		lesman	1)		Clothi	ng					
be filed ital Hygi d other evant, I	e)	17. Father's Name (First, Middle, Last Jesse Weatheri				18. Mother's Nam Clara			ne)					
should be and Mental marked o	5	19a. Informant's Name/Relationship		19b. Maili	ng Address (Street	and Number or Rui			State, Zip	Code) 20772				
alth ar		Florence Weatheri	ngton (Wife)		and the second s		_			rlboro MD				
permit. Pages 1 and 2 should be Department of Health and Menia Important: If I tem 27 I is marked any injury or other traumatic evone.		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3	Tremoval non State Mars	lace of Dispo emetery, cre v 1 a n d	osition (Name of matory or other plac Veterans	Jan Cem. 2006	Date 18,	20c. Location -	_	own, State Maryland				
nit. Pa artmer ortant injury		4 ☐ Donation 5 ☐ Other (Special Service) Lice	,,			ss of Facility Le								
Perr Imp		Hours J. Fron	mooas7						lint	on, MD2073				
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. CONGESTIVE LEART PAILURE												
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)			STIVE	HEART	FAIL	URE						
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ntificating physes the		IF FEMALE:												
Hospital or Attending Physician: The law requires that the death cert is hours after death. Funeral Director: After this certificate has been signed by the attendintely filled in by the funeral director, page 2 should be detached for use	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of di 9 ☐ Unknown	Ideath 3	□Ectopic pregnanc □ Other (specify) _	у			te of deliv	ery Day Year				
s that t ned by e detai	by Ph	Part II. Other significant conditions			underlying cause giv	ven in Part I.	23e. Did	tobacco use con	tribute to t	the cause of death?				
equire equire en sig ould b	ted t	14.	{PERTENSION				1 🗆	Yes 2□No	3 Prol	bably 4 Mknow				
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lor Attending Physician: The law requires that the dater death. Director: After this certificate has been signed by the in by the funeral director, page 2 should be detached	Be	25. Was case referred to medical examiner?	Hospital:		Ott	26. Place of Dea			- /0	, .				
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or Atte after de Directo	Certification:	3 Surcide 6 Could not determine			treet, factory, office			(Street and Numi own, State)	ber or Run	al Route Number,				
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441		30. Name and address of person wh	completed cause of death (Item			Y ION II	Y NITCH	(1) (5 n.	10	าดารา				
10.5	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	C 103 DVR	1 12: 10	1 .41 30	(CC) 10	٠ ر٠	20.01				
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DHMH 17 Rev 1/2001

Weatherington, Melvin

			Please Type of Print in Black Indelible Ink. Ensure All Copies are Legible.	e as to
			1- State of Maryland / Department of Health and Mental Hygiene Certificate of Death	
	Physicia /Medic	an	BERIL ZIPPER January 10 2006 7	30 PM
	Examin	1	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Ac. County of Death N/A	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 F 86 Yrs. 1 Months Days Hours Min. OCT.10,1919 9. Birthplace (Sta Country) OCT.10,1919 9. Birthplace (Sta Country) GERM.	
			Tod. State Tob. County	e City Limits
	e Mary	ctor	FID DALITHORE RETURNS	res 2 No
45	3a or 2	al Dire	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 564 KENNINGTON ROAD 21136 USA	
7 pper	within 72 hours after deeth with the Maryland ene. then "natural", or tems 23a or 28a-f show the Medical Exercit or most be notified at	Be Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Midowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Specify: 13. Was Decedent of Hispanic Origin? (Specify Yes or Nollif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes 2 No Specify: Specify: WHI	
215-003	thin 72 hours e. sn "natural", Medical Exe	npleted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry	
Ben7	oe filed tal Hygi d other		2 SEAMSTRESS GARMENT 17. Father's Name (First, Middle, Last) MTCHAEL SELIG RACHEL LEV	т
ar La	d 2 should the and Ment	은	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
G S	a la s		MICHAEL ZIPPERT / SON 9328 OLD COURT ROAD - BALTIMORE, MD 21244 20a. Method of Disposition (Name of cemetary, crematory or other place) 20b. Place of Disposition (Name of cemetary, crematory or other place) 20c. Location - City or Town, State	9
Known Baltimore	Page ment o ant: if ury or		1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) CHEVRA AHAVAS CHESED 01/12/2006 RANDALLSTOWN,	
Balt	permit Pag Department Important: I any in ury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 2	
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval	
-	/Medical Examiner		resulting in death)	
· by	p ii	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	
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	quires that in signed by	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of the ca	of death?
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Vital	ician: certifica ector, p	Be	25. Was care referred to medical exampler?	
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:0:	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marc H. Gerre, M. 23 Crossrouds Dr. #240 Owing Mills, Mr.)21117
	St Regist	ate rar	31. Date filed (Month, Day, Year) JAN 1 3 2006 32. Registrar's Signature	

			For L State	State of Maryl	and / Dep		ealth and N		ene 0.06	00618
			Registrar		Ce	rtificate of l	Jean		J. No.	3. Time of Death
	Physicia		Decedent's Name (First, Middle, L.					2. Date of Death Month	Day Year	M
	/Medic	al	Terry Allen		Jr.			January		5·45 P M
	Examin	er	4a. Facility Name (If not institution, gr				Location of Death		4c. County of Deat	
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	Funeral		o. Gooia, Goodin,	157M 2□ E	yrs. last birthday, /. Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,)	(ear) 9. Bin	hplace (State or Foreign
	Director		214882351 Usual Residence of Decedent	3	4 Trs.			Oct. 16,	19/1	<u>laryland</u>
	and a		10a. State 10b. County	10c	. City, Town or L	ocation				10d. Inside City Limits
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	28e-	ect	10e. Street and Number	rrett		10f. Zip Code	nton	10	g. Citizen of What Co	ountry?
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	eath	era	11. Marital Status	12. Was Decedent Ever	in U.S. 13.	Was Decedent of H		pecify Yes or No-	USA 14. Race - Ame	
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b	be filed ital Hygir id other event, I	Be (17. Father's Name (First, Middle, Las	st)			18. Mother's Nam	ne (First, Middle, Ma	aiden Sumame)	
<u> a</u>	Ments Ments arked	2	Terry Allen	Artice,	Sr.		Clara	Mae	DeWitt	
Maryland 21215-0036	2 should be and Menta Is marked eumatic ev		19a. Informant's Name/Relationship	(Type, Print)					City or Town, State, .	
Σ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23e or 28e-f show any njury or other treumatic event, the Mydical Examiner must be multiled at once.		Eugenia M. Artic			W-1-1			Md. 21561	
Baltimore,	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	□Removal from State	b. Place of Disp cemetery, cre	osition (Name of ematory or other plac	ce)	Date 2	Oc. Location - City or	lown, State
Ĕ	Pag ment ent: I ury o		`4 □Donation 5 □ Other (Spec		eer Parl	k Cemeter	y 1/7/	2006 1	er Park,	Maryland
att	permit. Departr Importe any Inj		21. Signature of Funeral Service Lis	₩. 5 00	2	22. Name and Addre	ss of Facility	32	S. Second	St.
m	89 5 2	- 8	Stower	Lew		Stewart F			cland, Md.	
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the ty one cause on each line.	death. Do not er	nter the mode of dyin	ig, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a Brain Met	astisis					3 Mos.
	/Medical		resulting in death)	Due to (or as a cor	nsequence of):					
	Examiner	Ш	Sequentially list conditions.	b. Pulmonary	Artery	Sarcoma				1 Year
	ם פ	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cor	nsequence of):					
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cor	acaguanga of\:					
760,	ate be executed hysician and the burial-transit	E E	Tooling in doday, 2201	Due to (or as a con	isaquanca oi).					
876	ate b	dical		d						
x 68	death certificat e attending phy id for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome of pr	ean ancy				22d Date of de	livon
Вох	ath c	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3	☐Ectopic pregnancy	/		23d. Date of de Month	Day Year
0	0 0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Fregnant at time 9□ Unknown	Oldean 5					
a	that the ed by detac		Part II. Other significant conditions	s contributing to death but no	t resulting in the	underlying cause giv	en in Part I.	23e. Did toba	acco use contribute t	o the cause of death?
Records,	Se de	d by	•	•				1 ☐ Yes	: 2 ☑ No 3 □ P	robably 4 Unknown
0	v require been si should I	Completed						24a. Was an	24h Wara a	utopsy findings available
3ec	elaw hasi	Id II						autopsy	ed? prior to death?	completion of cause of
A F								1 Yes 2	K No 1 □ Yes	3 2 □ No
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		O# 0#	er	th (Check only one		
o	Phys this al dii	2	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Linpatient	2 ER/Outpatie	ant 3 DOA	4 Nulsing H	ome 5 K Hesider 28d. Describe hov	rce 6 ⊡Other (Spe vinjury occurred	эспу)
		lon	1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	ar) Injury	Wo	k? Yes 2□No			
Si	Attending r death. sctor: After by the fune	ical	3 Suicide 6 Could not	be ago Place of Injury	At home, farm, s			28f. Location (Stre	eet and Number or R	ural Route Number,
Division		Certification:	4 Homicide determine	building, etc. (S	pecify)	,		City or Town,	State)	
1			29a. Certifier 1 ☑ Certifying	Physician. To the best of my	y knowledge, dea	ith occurred at the ti	me, date and place	, and due to the car	use(s) and manner a	s stated.
		edical	(Check only 2 Medical Ex	aminer. On the basis of exa and manner stated.	mination and/or i	nvestigation, in my	pinion, death occu	rred at the time, da	te and place, and du	e to the cause(s)
	To the Hospite within 24 hours To the Funerel completely filled	₹ E	29b. Signature and title of confiner	//	, ,	29c. Licens	se number	29	d. Date signed (Mon	th, Day, Year)
	F 5 F Ö		► (AH//		-14	D2:	3979		1/5/0)6
60			30. Name and a dress person	o completed cause of death	(Item 23a) (Type	e, Print)			-/-/	
			Robert A. Gor			Fourth St	., Oaklan	d, Md. 21	550	
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's		4				
	Regist		JAN - (2006	J. A.	Cooks				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 1010 Stewart Wayne Burton)'d /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner GCRED HEART HOSPITAL MBERLAN If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Aug. 30, 1947 Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Months Hours XXM 2 F ntry) MD 58 Director 235-68-8838 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heelth and Mental Hygiene. and if filem 27 is marked other then "natural", or items 23a or 28a-f ehow ary or other traumatic event, if a Medical East inferterment he inclined at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 1 Tyes 2 No Director Hampshire Paw Paw 10q. Citizen of What Country? 10e. Street and Number 10f. Zip Code 25434 **USA** Rt. 1 Box 105 Be Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11, Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 Furniture Building Laborer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 Hilda Goliday <u>Stewart E. Burton</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Freda E. Burton (wife) Rt. 1 Box 105 Paw Paw, WV 25434 20b. Place of Disposition (Name of cemetery, crematory or other place)

Island Hill
Lemetery 20c. Location - City or Town, State 20a. Method of Disposition 1/06/06 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment o importent: if eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Paw Paw, WV 22. Name and Address of Facility 21. Signature of Funeral Service Licenses McKee Funeral Home Inc. P.O. Box 270 Augusta, WV 26704 23a. Part1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical SMALLCELL LARCINOMA LUNG **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physicien and s the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical use as the signed by the attending I be detached for use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 1 No 1 Yes 2. No 1 Yes 25. Was case reterred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 / Inpatient 1 Yes 2 № No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 5 Pending 1 Natural efter death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, tactory, office building, etc. (Specify) in by 4 - Homicide To the Hospitel of within 24 hours ell To the Funerel C Hospitei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and the of certifier 3,2006 123371 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 635 Kent Avenue Cumbercout, ND 21502 DR Qamar Zaman 31. Date filed (Month, Day, Year) 32. Signature State Registrar 2006

			1 - For State of Registrar	f Maryland / Dep Ce	partment of Hea ertificate of De	ulth and Mental Hygeath	gienê () () (5 00620
			Decedent's Name (First, Middle, Last)			2. Date of Dea Month		3. Time of Death
	Physicia /Medic		Ruth Sarah	Burge	55	I I		C 0935 AM
н	Examin		4a. Facility Name (If not institution, give street and nu.	mber)	4b. City, Town, or Loc	cation of Death	4c. County of I	1.1
			OAKLAND NUNG IN		Oalco	Under 24 Hrs. 8 Date of Birt	Gan	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda) 90 Yrs.		lours Min. (Month, Da	Y. Year) 1915 M	Birthplace (State or Foreign Country)
	Director		217-10-7200 Usual Residence of Decedent			riay 3,	1717 1	
	yland		10a. State 10b. County	10c. City, Town or I	ocation			10d. Inside City Limits
	Mar s	ctor	MD Garrett	Swanto	n			1 Yes 2 No
	or 28	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of Wha	at Country?
	ath w	la	3386 Swanton RD	delat Constitution 100	21561	nic Origin? (Specify Yes or No	USA	American Indian.
	ter de	Funeral	11. Marital Status 1 □ Never Married 1 □ Never Married 2 □ Married 1 □ Yes	rces?	If Yes, specify Cuban, M	Mexican, Puerto Rican, etc.)		White, etc.
38	urs aff	by	3 Widowed 4 Divorced Year or D	/8	1 ☐ Yes 2 No S	pecify:	Specify:	White
Š	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show edical Examiner must be nutilized at	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Dec	edent's Usual Occupation te kind of work done durin	na most of working	16b. Kind of Busin	ess/industry
218	d within 7 jiene. ir than "r ine Med	Completed	Elementary/Secondary (0-12) College (1-4or 5+) life.	DO NOT use retired)	g most of working	-	
21			17. Father's Name (First, Middle, Last)	Но	memaker	Mother's Name (First, Middle,		eeping
and	a la b s	Be			10.	Virgis Virgin		0
Maryland 21215-0036	s 1 and 2 should I Health and Men itam 27 is marke other traumatic	2	Elijah Clark Wolford 19a. Informant's Name/Relationship (Type, Print)	19b. Ma	ling Address (Street and	Number or Rural Route Number		
Ma	nd 2 sho alth and 27 is mu ir traumi		Robert C. Ford (son)		71 Box 105G			
	f Hea f Hea itam otha		20a. Method of Disposition	20b. Place of Disp		Date	20c. Location - Cit	y or Town, State
ê E	0 0		1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State	i F.H. PA	1/1/06	Cresapto	wn, MD
Baltimore,	permit. Pag Department Important: any injury o		21. Sonature Funeral Service Licensee	Plus	P.O. Box 2	70 Augusta. W	V 26704	Inc.
			23a. Part1. Enter the disease, or complications that a shock, or leart failure. List only one cause on a	aused the death. Do not e	nter the mode of dying, s	uch as cardiac or respiratory ar	rest,	Approximate Interval Between
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	/Medical Examiner		resulting in death) Due to	(or as a consequence of):				
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	ted	nine	cause. Enter Underlying Cause (Disease of injury	(or as a consequence or).				
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Box	leath certifica attending ph i for use as th	Physiclan/Medical	23b. Was decedent pregnant	tcome of pregnancy birth 2 Petal death 3	☐Ectopic pregnancy		23d. Date o Month	f delivery Day Year
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Vital Records,	has ge 2	Completed	Cever, according	4	47	autop perfo	sy prio med? dea	r to completion of cause of th?
le		e Co	25. Was case referred to medical	avollom	JON 122	1 ☐ Yes		Yes 2□No
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Division	or Attano after death Director: in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place build	of Injury - At home, farm, sing, etc. (Specify)	street, factory, office	28f. Location (S City or Tow		or Rural Route Number,
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	To the Hospital or Attan within 24 hours after deat To tha Funaral Director: completely filled in by the	edical	29a. Certifier Certifying Physicien: To the (Check only one)			on, death occurred at the time,	date and place, and	due to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier		29c. License nu	mber	29d. Date signed (A	Nonth, Day, Year)
			Paul Dan Duck	Ver pe	1+26	154	11	1106
	3		30. Name and address of person who completed cau	se of death (Item 23a) (Type e - 69 0 0	a. Print)	Drive Oak	(and)	MD 2000
	Sta Registr			Registrar's Signature	apple		1	
	negisti	ul	JAN 0 9 2006 🚜	Missel De 19				

			•	ype or Print in Black i State of Maryland / Dep			•	•	00621
		_	State Registrar	Ce	ertificate of			. No.	00061
	Physici	an	1. Decedent's Name (First, Middle, Last) DEAN BLOODSWO	RTH			Date of Death Month ANUARY	Day Year 3 2006	3. Time of Death 10:30p M
	/Medic Examin		4a. Facility Name (If not institution, give st	reet and number)	4b. City, Town, o	r Location of Death		4c. County of Dea	
			58 Lake Dr.		Earle			Ceci1	
I	Funeral Director		222-38-0689	7. Age (In yrs. last birthda M 2 F 54 Yrs.	y) If Under 1 Year Months Days	Hours Min.	Date of Birth (Month, Day, Y		thplace (State or Foreign puntry) ryland
	land		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits
	Mary I et	tor	MD Cecil	Earle	/ille				1 ☐ Yes 2 💆 No
	th the)Irec	10e. Street and Number		10f. Zip Code		100	g. Citizen of What C	ountry?
	ath wi	ral	58 Lake Dr.		21919			S.A.	riana Indian
036	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or items 23a or 28a-f show event. If a Madical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2⊠ Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 22 No	dispanic Origin? (Speci an, Mexican, Puerto Ri Specify:	ty Yes or No- can, etc.)	14. Race - Am Black, Whi	
21215-0036	72 hou	Completed by	15. Decedent's Educ (Specify only highest grade	ation 16a. Dec	cedent's Usual Occup	oation during most of working d)	16	b. Kind of Business	/Industry
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ore	ges 1 au t of Hea if item or othe		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State cemetery, c	sposition (Name of rematory or other place			oc. Location - City o	
Baltimore,	t. Pag rtmen rtant:		*4 □ Donation 5 □ Other (Specify)	Betner	Cemetery				ke City, M
Bal	permit. Pages Department of t Important: if its any injury or of		21. Signature of Fineral Service License	MOUSIU	LI8_West	Cross St	 Gale 	na, MD.	
			23a. Part : Enter the disease, or complice shock, or h-art failure. List only on			ng, such as cardiac or	respiratory arres	t,	Approximate Interval Between Onset and Death
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Division of Vital Records,	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28	Bf. Location (Stre City or Town,	et and Number or F State)	lural Route Number,
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	. 0		30. Name and address of person who co	mpleted cause of death (Item 23a) (Ty		1000			
_	12		Jamil Khatri,		High St.	Suite 10	4 Elkt	on, MD.	21921
		ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	a de la				
	Regist	rair	JAN 1 0 2006	places to pige	No. of the second				

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State

Registrar

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2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrer Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year 11:50 AM Month **Physician** 5, 2006 Frances Patricia Burnette January /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Mary's Hollywood 43900 Sandy Bottom Road If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🗶 F 64 Maryland 577-84-2779 January 29,1941 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 X No Funeral Director St. Mary's Hollywood Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20636 USA 43900 Sandy Bottom Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or itema 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify: Completed by 3 X Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7: Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "ns any injury or other traumatic event, it a Mustic once. Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be James Dawkins Abell Mary Violet Dean ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael S. Abell, Sr. / Brother P.o. Box 133, Hollywood, Maryland 20636 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition January 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Our Lady's Cemetery 10, 2006 Leonardtown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A Frichael Klern 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. P.O. Box 270, Leonardtown, Maryland 20650 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CLUCER Physician MONTHS /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Be Completed by ARTIRY DISABLE 1 Yes 2 No 3 Probably 4 Unknown URONAM 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death? MELLITUS DIABATAS page 2 1 Yes 2 No 1 Yes 2 X No the Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 M Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending 1 Yes 2 No investigation death. 2 Accident I Director: d in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai (Check only one) and manner stated within 2 To the F 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D001952 Bannett 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) By the mill Rd California, MD 20019 L. Bennett 23063 10hn 31. Date filed (Month, Day, Year) 32. egistrar's Signature State 2006 JAN 0 6 Registrar

			1 - For State Registrar	State of Man		artmei ertifica			and Me		giene Reg. No.	006	00624
	Physici		Decedent's Name (First, Middle, Last)	Irvin L	aVerne (Crous	е			2. Date of Dea Month January	Day	2006	3. Time of Death
· ve	/Medic Examin		4a. Facility Name (II not institution, give s Carroll Hospital	Center		We	stmin		of Death		4c. C	ounty of Deat	County
	Funeral Director		5. Social Security Number 213–24–9741 Usual Residence of Decedent	7. Age (//	n yrs. last birthday 76 Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da) May 30	v, Year)		hplace (State or Foreign untry) yland
	ne Maryland 8a-f ehow	ctor	10a. State 10b. County Maryland Carroll		Oc. City, Town or L Taney	ytown							10d. Inside City Limits 1 ☐ Yes 2X No
	23a or 2	Funeral Director	10e. Street and Number 3224 Harrney Road			10f. Z	p Code	217	787		_	en of What Co ed Stat	,
5-0036	within 72 hours after deeth with the Maryland ene. Then "natural", or items 23a or 28a-f ehow he Medical Examinar must be notilied at	þ	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Was Decedent Eve Armed Forces? MYes 2 □ No If Yes, Give Year or Dates:	1952- 1953	Was Deci If Yes, spe 1 \(\superset\) Yes		spanic Orig n, Mexican Specify:	gin? (Spec , Puerto F	cify Yes or No- lican, etc.)	1	Race - Ame Black, White pecify: Wh	a, etc.
21215-0	be filed within 72 hours after deeth with the Marylar dia Hygiene, and Hygiene, other than "natural", or items 23s or 28s-f show other than "natural", or items 73s or 28s-f show event, the Madical Examinar must be notified at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	edent's Usi e kind of w DO NOT	ork done d use retired	luring most)	t of workin	g	gove	of Business/ ernment allati	
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	1 and 2 sh Health and em 27 le m ither traum		19a. Informant's Name/Relationship (Type Betty L. Crouse /	wife	322	4 Har	ney F	Road		Route Number			
altimore,	-I ==		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)		20b. Place of Disp cemetery, cre Haugh's				Jan	1. 12 2006		sburg,	Town, State Maryland
Balti	permit. Pages Depertment of Important: If It any Injury or o		21. Signature of Fineral Service License	A	2	22. Name a	nd Addres	s of Facility	y Ski	les Fu	neral Tane	Home ytown,	Md. 21787
68760,	Certificate be executed displaying physician and displaying the purial-transit.	dical Examiner	23a. Part1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Exquantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	onsequence of): Onsequence of):	we an	Fai (a	lewe	, ,		rest,		Approximate Interval Batween Onset and Death
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	The law requires that the de- ste hes been signed by the e- page 2 should be detached f	by	Part II. Other significant conditions con	tributing to death but n	oot resulting in the	underlying	cause give	en in Part I.					the cause of death?
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VIII VIII	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:			Othe)C		Check only o			
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Divis	P # F	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At home, larm, s Specify)	treet, facto	ry, office		2	8f. Location (5 City or Tox	Street and In, State)	Number or Ru	iral Route Number,
	To the Hospital within 24 hours e To the Funeral Completely filled	Medical	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examination)	sician: To the best of ner: On the basis of ex and manner states	amination and/or i	ith occurre nvestigatio	d at the tim n, in my op	e, date and pinion, deat	d place, at th occurre	nd due to the o d at the time,	cause(s) a date and p	nd manner as lace, and due	stated. to the cause(s)
	With To t	Σ	29b. Signature and title of certifier	0		1	c. License					signed (Montt	* '
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6	/tl		30. Name and address of person who co	rain M-D-	447,	Eas,	L Ma	in St	Vee t	West	wins,	ter h	0 21157.
	Sta Registi		31. Date filed (Month, Day, Year)	egistrar's	Signature	50							

IRVIN LAVERNE

			For State Registrar	State of Ma	aryland / Depa <i>Cel</i>	artment rtificate			and Me		giene Reg. No.	006	006	25
			1. Decedent's Name (First, Middle, La	st)					2	2. Date of Dea	ath			of Death
	Physici /Medic		Rev. Ra	wmond G.	Collins, 0.	S.F.S				January	v 5	2006	1	5 P M
	Examir		4a. Facility Name (If not institution, give		,			Location of				County of De		
			Annecy Hall				.1ds				(Cecil		
	Funeral		5. Social Security Number 6. S	VIM OF E	e (In yrs. last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	B. Date of Birt (Month, Day May 25	h y, Year)		Birthplace (Stat Country)	
	Director		160-24-9856 Usual Residence of Decedent		30 Yrs.				1	lay 25	, 192	.5 P	ennsylv	ania
	land ow		10a. State 10b. County		10c. City, Town or Lo	cation							10d. Inside	City Limits
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	n the	irec	10e. Street and Number			10f. Zip	Code				10g. Citiz	en of What	Country?	
	th wit	aiD	1120 Blue Ball R	oad		21	916				Uni	ited S	tates	
	ams erra	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decede	ent of Hi	spanic Ori	gin? (Spec	ify Yes or No-	- 1	4. Race - Al Black, W	merican Indian,	
36	or it		1 Never Married 2 Married	Armed Forces? 1 XYes 2 1 If Yes, Give Year or Dates:	War II	1□Yes 2		Specify:						
21215-0036	72 hours after death with the Maryland netural; or Itams 23s or 28s-f show lical Exartination Incilling all	Completed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's E			dent's Usua	I Occupa	ation					White	
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	e filed I Hyg other	Be C	17. Father's Name (First, Middle, Last,							First, Middle,				
lar	utd be Aenta rked tic ev	To B	William Collins					He1e	en Mc(Garvev				
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	es 1 and 2 of Health of litem 27 I		Oblates of St. Fra	ncis de Sa				Park	way,	Wilmin	gton,	, Dela	ware 19	9806
Baltimore,	of He		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Dispo cemetery, crea	osition (Nam matory or ot	e of her plac	₉₎ J	anuar	y 12,	20c. Loc	ation - City	or Town, State	
Ë	perrit. Pages Department of I Important: If ite any injury or of		* 4 ☐ Donation 5 ☐ Other (Specif	y)	Oblate C		-		2006		Chi1	ds, M	aryland	
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	/Medical Examiner		Tooling in doubly	Due to (or as	a consequence of):	18								./
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Ö	s afte	Sert	4 Homicide	building, e	tc. (Specify)					City or Tov	vn, State)			
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	he Hin 24 ha Fi	edicai	one) 2 Medical Exam	and manner st	of examination and/or in ated.	ivestigation,	in my of	oinion, dea	ith occurred	at the time,	date and p	place, and c	due to the caus	e(s)
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fun	Σ	29b. Signature and title of certaler	11/1	10 0	1		number			29d. Date	signed (Mo	onth, Day, Year)
•				CK 1/4	X M		:2-	000	22.5	0		161	do	
	10X1		30. Name and address of person who											
	`		Christine E.K. Ho		412 Subur	ban Pl	laza	, New	ark,	Delawa	re 1	9711		
	Sta		31. Date filed (Month, Day, Year)		rar's Signature	والمعاد								

			For State Registrar		State	of Mar	yland / D		rtment tificate					giene	U U D		00627
	Physici	an	1. Decedent's Name (_{vson} Can	mbe 1	1 Tm						2. Date of De Januar		2006	əar	3. Time of Death
	/Medic Examin		4a. Facility Name (If no	ot institution, gi		ımber)	1, 51.		4b. City, T		Location o		Januar	4c.	County of Frede	Death	5:50 AM M k
200	Funeral Director		5. Social Security Num 408-32-29	14	Sex 2□F	7. Age (In yrs. last birtl	hday) rs.	If Under 1	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Aug • 2	th Year)	926 T	Birthp Cour enn	place (State or Foreign ntry) ESSEE
	aryland show			0b. County	-1-	1	0c. City, Town									1	0d. Inside City Limits XXYes 2 □ No
	with the Ma Sa or 28e-f	Direc	10e. Street and Number		Crest La	ne	Freder	TCK	10f. Zip	Code 217	02				zen of Wha	at Cour	
5-0036	be filed within 72 hours after death with the Maryland ital Hyglene. Id other than "natural", or iteme 23a or 28e-f ehow event, the Medical Exertical records to notified at	by Funeral	11. Marital Status 1 Never Married 3 Widowed 4	2[XMarried	12. Was Dec	cedent Ev	er in U.S. Y4-19 46		/as Decede Yes, speci		spanic Ori n, Mexicar Specify:		cify Yes or No Rican, etc.)		14. Race - Black, Specify: V	White,	etc.
1215-0	within 72 ho iene. than natur the Medical	Completed	(Specify Elementary/Second Q		rade completed) (1-4or 5+)		(Give k life. D	ent's Usual and of work ONOT use	k done d e retired)	u <i>ring mo</i> s		_		nd of Busin		dustry
aryland 2121	b d d d	To Be C	17. Father's Name (Fit		n Campb	ell,	Sr.				18. Mothe	sie ((First, Middle, Goodwir	, Maiden	Sumame)		
≥	and 2 sho balth and n 27 le m		19a. Informant's Nam Debbie W.			ter	19b.	Mailing 11 0	Address 2 Eag	(Street a	nd Numbe Cace	or Rura Dr.,	New Ma	er, City o arket	r Town, Sta	ite, <i>Zip</i> 2177	74
altimore,	permit. Pages 1 and 2 should Depertment of Health and Men Important: If item 27 ie marke arty injury or other traumatic Oute.		20a. Method of Dispos 1XX Burial 2 0 4 0 Donation 5	Cremation 3 ☐ Other (Spec	(h)	n State	20b. Place of cometery Resthave	Dispos v, crem En Me	ition (Nam atory or oti MORIA	e of her place 1 Gar	dens J		, 2006		ederic		wn, State Maryland
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8760, ~	ate be executed hysician and the burial-transit	dical Examiner	Sequentially list condition if any, leading to imm cause. Enter Underly Cause (Disease or in) that initiated events resulting in death) Las	ing ury	Due to		sion consequence of										Years
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HENRY P. BULLOCK Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Unpend item#1,23a,27.pen/E.0852.2/9/06 TT
State of Maryland / Department of Health and Mental Hygiene () () 06-0069 RKD Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Henry P. Bullock, Sr. Henry Patrice Bullock JANUARY 3, 2006 8:27A. /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner PRINCE GEORGES CHEVERLY PRINCE GEORGES HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 **□X**M 2 □ F 41 Rocky Mt., N.C. Yrs. 579-90-0866 Director 9/14/64 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other then "natural", or iteme 23a or 28a-f show vant, tre Medical Examinar must be notified at Washington D.C. 1 X Yes 2 ☐ No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20032 U.S.A. 912 Southern Ave., S.E. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 □X'es 2 □ NP 1Y'es, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White etc. African-1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: American Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Dept. of Public Works Security Officer 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mental Patricia Ann Bullock Pages 1 and 2 should be Unknown ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2453 Kenbrook Ct., Waldorf, Md. 20603 Health tem 27 i Patricia Ann Bullock/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Depertment of H Important: If ite eny injury or ot sace. Ft. Lincoln Cem. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/9/06 Brentwood, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
H.S.Washington & Sons Co., Inc. TIEU aure 4925 Burroughs Ave., N.E., Wash., D.C. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Enysician Cardiac Arrhythmia /Medical Due to (or as a consequence of): Examiner Dilated Cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) physicien and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical ding IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 □Ectopic pregnancy atter for u 2 Fetal death Month Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9☐ Unknown 9 Unknown s been signed to should be detr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 □ No 24a. Was an autopsy performed? certificete 12 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: ို

the Hospital or Attending Physician: The law requires thet the death certificate be executed Division of Vital Records, this After thi funeral death. within 24 hours efter death To the Funeral Director: / completely filled in by the f

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide 1 Certifying Physician: To the best of my knowledge ideath oncomed at the time, date and place and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Pile Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

O.C.M.E.

JANUARY 4, 2006

111 PENN STREET BALTIMORE MARYLAND 21201

Va State

DHMH 17 Rev 1/2001

Certification:

Medical

31. Date filed (Month, Day, Year)

30. Name and address of person who completed suse of death (Item 23a) (Type, Print)

2. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 2006 1535 PM January Aleclia Ann Dilks 4 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ceci1 Laurelwood Care Center E1kton If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year SEPT 19, 193 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Hours 1 □ M 2 1 F Months Min. 75 Director 215-28-3740 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-1 show any injury or other traumatic event, Ite Modical Extraination ust be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 TyYes 2 No Completed by Funeral Director Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 100 Laurel Drive 21921 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes 21XNo Specify: Specify: If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) In Her Own Home 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Lockwood Price Ruth Rena Willoughby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry L. Cullum/Nephew 137 North Tartan Drive, Elkton, Maryland 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition January 10, 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Elkton Cemetery Elkton, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Renal /Medical Due to (or as a consequence of) Examiner Dicelos melle if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed alla Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy fistings available prior to completio, of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed 1 Yes 2 No Division of Vital the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No dif 2 1 🗌 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 1 Yes 2 No death. 2 Accident investigation Director: , 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Jui ale HA- MD DO4823 1/6/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUI CHILT HOW MID 223 Weit main St 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

			For State Registrar	State of M	laryland /	_	artmen rtificate			ınd M		giene Reg. No.	06	00	630
			1. Decedent's Name (First, Middle,	Last)					•		2. Date of Dea	ath Day	Ye		Time of Death
	Physicia /Medic		MAXINE WEST	CERVELT	DARBY						JANUA		2 200		0:15a ^M
	Examin		4a. Facility Name (If not institution,	give street and number	r)		4b. City,	Town, or	Location of	f Death		4c.	County of D		
			Talbot Wing -						rtown				ent		
	Funeral			i. Sex 7. A 1 ☐ M 2KD F	nge (In yrs. last b 94	virthday) Yrs.	Months	Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day	y, Year)		Country)	(State or Foreign
	Director		182-36-2865 Usual Residence of Decedent		94	710.					Apr 18	19	11 Ne	ew Je	ersey
	yland		10a. State 10b. County		10c. City, To	wn or Lo	cation							10d. lr	nside City Limits
	Maries	io	MD Kent		Ches	ste	rtowr	า						1	Yes 2 □ No
	death with the Maryland ims 23e or 28a-f show ir must be notified at	Director	10e. Street and Number				10f. Zip	Code				10g. Citi:	zen of What	t Country?	
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	be filed within 72 hours after death with the Marylan tal Hyglene. d other than "neturel", or liems 23e or 28e 1 show event, the Medical Franciar must be routiled at	Funeral	11. Marital Status	12. Was Deceden Armed Forces	s ?	13.	Was Deced	lent of His	spanic Orig n, Mexican	gin? (Spe , Puerto	cify Yes or No- Rican, etc.)		14. Race - A Black, W	American In Vhite, etc.	dian,
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yland		To	Whitely P. W	estervel:	t				Eth	e1 /	Adams				
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	tmen tent:		'4 □Donation 5 □ Other (Spe		West				i	L/6/	06	Бал	.a Cy	nwyd	, PA.
g n	permit. Pages 1 Department of H Importent: If Ite eny Injury or ot 2005e.		21. Si est and Frineral Service Li		M00510	G_{1}^{2}	alena 18 We	a Addres Fu est	s of Facility nera Cros	1 H s S	ome of t. Gal	St ena	epher MD	n L. 216	Schaecl 335
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	/Medical Examiner		resulting in death)	Due to (or a	is a consequence	e of):									
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ρ	ificate g phy as the	edic		u											
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	deati	icia	in the past 12 months? 1 Yes 2 No	4□Pregnant	at time of death		Other (sp						Month	Day	Year
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		-	For State Registrar	State of Maryla	-	artment of F rtificate of			jiene Nog. No. 0 (6 00631
	Physicia	an	Decedent's Name (First, Middle, Last		Durbin			2. Date of Dea Month	Day 70	3. Time of Death
}	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	Julbill		or Location of Death	01-	4c. County o	
			502 Broadway Circ 5. Social Security Number 6. S		s. last birthday)	Cumber If Under 1 Year	land If Under 24 Hrs.	8. Date of Birth	Allega	9. Birthplace (State or Foreign
1	Funeral Director		216-22-5361	^{□ M 2} √x 78	Yrs.	Months Days	Hours Min.	Jun 29	, 1927	MD
	yland now		Usual Residence of Decedent 10a. State 10b. County	l l	City, Town or Lo					10d. Inside City Limits
	Be-fet	ector	MD Allegai	ny	Cumi	berland				1 □X es 2 □ No
	3a or 2	II Dir	10e. Street and Number 502 Broadway Cir	cle		10f. Zip Code	21502		10g. Citizen of W US	•
9	be filed within 72 hours after deeth with the Maryland Hygiene. All Hygiene. do ther then "natural", or items 23a or 28e-f ehow do ther then "natural", or items 23a or 28e-f ehow event, if a Modical Exactical must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		Was Decedent of H If Yes, specify Cub	dispanic Origin? (Spean, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		- American Indian, , White, etc. White
5-0036	2 hour atural	ted b	3 XVidowed 4 Divorced	Year or Dates:	16a. Dece	dent's Usual Occur	pation		16b. Kind of Bus	· · · · · · · · · · · · · · · · · · ·
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Maryland		To	William Crawfor 19a. Informant's Name/Relationship (10: 14: 11			et E. Sti		,
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ნ .	permit. Pages 1 e Depertment of Hee Important: if item eny injury or othe		20a. Method of Disposition 1 □ Surial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	cemetery, cre-	osition (Name of matory or other pla Veterans C	ce)	1/6/2006	20c. Location - C	ne MD
Bal	Dependitude of the control of the co		21. Signatur of Funeral Service Licer	See MM	- 2		llî funeral Ho ginia Avenue		land MD 3	21502
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Divis	tai or Atters after des ef Directored in by the	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, st ecify)	reet, factory, office		28f. Location (S City or Tow	Street and Numbe m. State)	er or Rural Route Number,
	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	Medicai	29a. Certifier 1 Certifying Pt (Check only one)	ysician: To the best of my liner: On the basis of exam and manner stated.	knowledge, Jeal ination and/or in	th secured at the travestigation, in my	opinion, death occur	and due to the red at the time,	date and place, a	iller as stated. nd due to the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier	1		29c. Licen			Ť,	(Month, Day, Year)
•			30. Name and address of person who	completed truse of death //	tom 22a) /T		D36766		1-4-	2006
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	Sta Regist		4557	32. Registrar's Sig	gnature	books				

State of Maryland / Department of Health and Mental Hygiene 1 1 5 1 - For State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2 Date of Death 3. Time of Death Month Day Year **Physician** DIGGS Jan. JUDE JAMES 8, 2006 5:15 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 3006 Dublin Road Street Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 8/28/1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 172 M 2□ F 69 Yrs. Director 220-32-4226 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Street MD. Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21154 3006 Dublin Road United States Funerai 12. Was Decedent Ever in U.S.
Armed Forces?
1 Yes 2 No
If Yes, Give
Year or Dates: Korea Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 21215-0036 1 □ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.
7 is marked other than 'traumatic event, the Me College (1-4or 5+) Elementary/Secondary (0-12) 9 Sewing Machine Mechanic Manufacturing Maryland 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Clara Vincent Ambrose Diggs Regina Alkire 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 3006 Dublin Rd. Mary Diggs Street, Maryland 21154 other ! Baltimore, 20a. Method of Disposition

1 ABurial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Injury or permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Air Mem. Garden 1/11/2006 Bel Air. Maryland Bel 22. Name and Address of Facility Jarrettsville, Maryland 21. Signature of Funeral Service Ligensee E.G. Kurtz & Son Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) 63 Privsician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 □ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Anesidence 6 Other (Specify) 1 Yes 2 Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. 28d. Describe how injury occurred 5 Pending s after de. ral Director: An 1 🗌 Yes 2 🗆 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide filled 24 hours a ecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2. To the ? 29b. Signature and tij 29c. License number 29d. Date signed (Month, Day, Year) 10 address of person who completed cause of death (Item 23a) (Type, Print) 3 gistrar's Signature 673 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygierre

Certificate of Death

Reg. No.

2. Date of Death

			1 - State Registrar	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Cei	tificate of l	Death		Reg. No.	Ub	00000
i	Physici		Decedent's Name (First, Middle, Last, Grace G		alliher			Jan 7, 2	2006 ^x	Year	3. Time of Death 5:00am M
	/Medic Examir		4a. Facility Name (If not institution, give Memorial Hospital			4b. City, Town, or Cumber	Location of Death			nty of Death	0.00411
	Funeral Director		Social Security Number 6. Se	x 7. Age (In yrs. ii M 2 XF 79	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir Jan 3,			place (State or Foreign
	Maryland f ehow	or	Usual Residence of Decedent 10a. State MD 10b. County Allegan	y 10c. City	, Town or Lo Cumb	perland				1	Od. Inside City Limits 1 Xes 2 No
	3a or 28a-	I Director	10e. Street and Number 701 Furnace Stree	t		10f. Zip Code	21502		10g. Citizen	of What Coun	ntry?
920	s should be filed within 72 hours after death with the Maryland and Mental Hygiene is marked other then "natural", or Items 23a or 28a-f ehow armatic event, the Madical Examinal must be redified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.: Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No Pican, etc.)		lace - Americ lack, White, cify: Whit	etc.
Baltimore, Maryland 21215-0036	d within 72 ho giene. er then "natu ine Medical.	Completed	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12)	le completed)	16a. Deced (Give life. I Homer	ent's Usual Occupa kind of work done of OO NOT use retired naker	ation furing most of work)	king	16b. Kind of	Business/Ind	Justry
/land	uld be file Mental Hy irked oth	To Be (17. Father's Name (First, Middle, Last) John H. Robey,	Sr.			18. Mother's Nam Elsie L.	(Conrac	, Maiden Sum d) Robe	ame) Y	
, Man	and 2 sho selth and I n 27 is ma er treums		19 Antomant's Named Palationship (T) Randy Galliner				and Number or Ru Et	ral Rove Numb	berrand	m, State, Zi	ฟ์ เ รี 21502
imore	permit. Pages 1 and 2 should be Department of Heelth and Menta Important: If Item 27 is marked any Injury or other treumatic es		20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	Removal from State Hill	lace of Dispo	sition (Name of Patory of the roles MOTIAI Park	e) 	Date 1/11/2006		n - City or To perland	
Balt	permit. Departimport any inj		21. Signature Fineral Service Licens	MIN	` 22	Nam Scarpel 108 Virg	≽ศิซิ กe val H inia Avenu			D 21502	
>	Physician /Medical Examiner		23a. Part Enfer the disease, or combined for heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused the death ne cause on each line. a. <u>CEREBROVASCUI</u> Due to (or as a consequ	LAR ACC		g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death I day
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	ence of).						
68760,	eath certificate be executed attending physicien and for use as the burial-transit	Medical Exa	resulting in death) Last	Due to (or as a consequent.	ience of):						
.O. Box 6	The law requires that the death certificate be executed tie has been signed by the attending physicien and bege 2 should be deteched for use as the burial-transit	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnar 1 ∐Live birth 2 ∐ Fetaf 4 ∐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)				Date of delive Month	ery Day Year
٥.	quires that the de n signed by the a uld be deteched f	d by Ph	Part II. Other significant conditions con	ntributing to death but not resu	ilting in the ur	dertying cause give	en in Part I.		obacco use co Yes 2 □ No		ne cause of death?
Vital Records,		Completed						24a. Was autoperfo	an 24l psy prmed? 2 No	o. Were autop prior to con death? 1 \(\text{Yes}	psy findings available npletion of cause of 2 No
	sicien: Th certificate irector, peg	Be	25. Was case referred to medical examiner?	Hospital:		Othe	26. Place of Dea				
Division of	ding Phys h. After this funeral di	tlon; To	27. Manner of Death 1 XNatural 5 □ Pending	1 Minpatient 2 Li	ER/Outpatien 28b. Time of fnjury	28c. Injury Work	4 Nulskiy Fi	ome 5 ☐ Resi 28d. Describe			2
Divisi	or Atten after deal Director: in by the	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	eet, factory, office		28f. Location (. City or To	Street and Nui wn, State)	mber or Rura	l Route Number,
	To the Hospitel within 24 hours a To the Funeral completely filled	Medical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred at the timestigation, in my op	e, date and place, pinion, death occur	and due to the red at the time,	cause(s) and date and plac	manner as st e, and due to	ated. the cause(s)
	To the within 2 To the Complet	M	29b. Signature and title of certifier.	1/2		29c. License D	36766		29d. Date sign		Day, Year)
	3		30. Name and address of pers in who co Vikramaditya Poo	nai M.D.	23a) (Type, 924 S	eton Drive	e Cumbei	rland ME			

State Registrar 31. Date filed (Month, Day, Year)

JAN 13 2006

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U 5 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Anna Glass 200^{Year}_{6} Mary **Physician** January 0700 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll County Taneytown 80 York Street If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6 Sex **Funeral** 1 ☐ M 2 🔀 F 217-32-7296 68 Sep 26 1937 Pennsylvania Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits or 28a-f show 1 X Yes 2 □ No Maryland Carroll County Taneytown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21787 United States 80 York Street or Iteme 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: white 3 □ Vidowed 4 □ Divorced Year or Dates "natural", 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) veterans' service club bartender 12 f Health and Mental Hygid Item 27 to marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Margaret Shields Bernard Norbert Kelly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 264 East Baltimore Street Taneytown, Md. 21787 Sharon A. Ohler / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan. 4 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Depertment of IImportant: If Ite
any Injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Joseph's Cemetery Taneyown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2006 21. Signature of Fungral Service Licensee 22. Name and Address of Facility Skiles Funeral Home Taneytown, Md. 21787 136 East Baltimore Street 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Md /Medical Due to (or as a consequence-of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physicien end for use as the burial-translt that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ate has been signed by I page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? No No 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospitaf: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2X No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred fnjury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide thin 24 hours a 29a. Certifie and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Westminister 291 Stoner CHACKO 31. Date filed (Month, Day 32. Regulrar's Signature State Registrar

PAUL W. HOLTZ 06-00194 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a,PII,27,28a-f,penMt,GSJ1,/19/06 TT State of Maryland / Department of Health and Mental Hygiene **RKD** 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Paul William Holtz JANUARY 2006 2:14 A. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK 4902 WISE ROAD CASCADE 6. Sex 1 M 2 ☐ F If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Director 215-18-1998 82 Yrs. June 25,1923 Maryland Usual Residence of Decedent the Maryland r 28a-f show 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Cascade Frederick Md. 1 TYes 2 XNo by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r then "natural", or iteme 23s or its Wedical Examiner must be c 4902 Wise Rd. U.S.A 21719 permit. Pages 1 end 2 should be filed within 72 hours after death v Depertment of Health and Mental Hygiene important: If Itam 27 is marked other then "natural", or Iteme 23a enty Injury or other traumatic event, Ita Mudical Examples experience and an angula. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 44 - 461 ☐ Yes 2 No 3 → Widowed 4 □ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Government Fireman 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Myrtle Ferguson George N. Holtz ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4902 Wise Rd. Cascade, Md. Ray M. Holtz (Son) 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Jan.11, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bethel Cemetery Cascade, Md. 2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. Mo1414 J.L. Davis Funeral Home Smithsburg, Md. 21783 AVIS Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Potential Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Head Injury Complicated by Hypothermia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospitel or Attending Physician: The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Completed by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the e 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Dementia; Parkinson's Disease 1 ☐ Yes 2 No 3 Probably 4 Unknown been si 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 □ No page 2 s this certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 MOther (Specify) SCENE Hospital: spital: 1 Inpatient 2 ER/Outpatient 3 28a. Date of Injury Find (Month, Day Year) 28b. Time of Find Injury ٩ 1 X Yes 2 ☐ No 3 DOA After thi 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Subject fell and Certification: 5 Pending 1 Natural 1 ☐ Yes 2 No death. investigation 1/8/06 1:50 A 2 X Accident
3 Suicide Director: was exposed to cold environment 6 ☐ Could not be 28f. Location (Street and August & Rural Route Number, City or Town, State) 4902 Wise Road 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours at To the Funeral D completely filled in found outside of residence Cascade , MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar 29b. Signature and title of certified

31. Date filed (Month, Day, Year)

2005

30. Name and address

DHMH 17 Rev 1/2001

person who completed cause of death (Item 23a) (Type, Print)

MIRCS

32. Registrar's Signature

29c. License number

O.C.M.E.

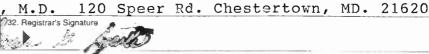
111 PENN STREET BALTIMORE MARYLAND 21201

29d. Date signed (Month, Day, Year) JANUARY 8, 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🛭 🕻 🕤 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician JANUARY EUGENE NOLAN HALEY 2006 11:30p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 31855 Jim Davis Rd. Galena Kent 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
| Months | Davs | Hours | Min. (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Birthplace (State or Foreign Country) 1<u>₩</u>M 2□F Yrs. 218-26-8691 Director 29 1929 Maryland Aug Usual Residence of Decedent with the Maryland 10a State 10b County 10c, City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ⊋No Director MD Kent Galena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 31855 Jim Davis Items 23a Rd. 21635 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 5 yes 2 □ No If Yes, Give Year or Dates: -1953 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after of and Mental Hygiene. 1 ☐ Never Married 2☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ White Specify: 3 ☐ Widowed 4 ☐ Divorced -1953Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Chemica1 Elementary/Secondary (0-12) College (1-4 or 5+) Chemical Engineer Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Earle Joseph Haley Martha Elizabeth Freeman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 st of Health ar (wife) 31855 Jim Davis Rd. Galena, MD. 21635 Jean Haley 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of Hi
Important: If Iter
any injury or oth 1 ☐ Burial 2 ☆Cremation 3 ☐ Removal from State 1/10/06 ' 4 ☐ Donation 5 ☐ Other (Specify) Kent Cremation Smyrna, DE. 21. Signatura of Furthral Service Lie 22. Name and Address of Facility Galena Funeral Home of Stephen L. Schaech M00510 118 West Cross St. Galena, MD. 21635 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Colon disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): 68760. physician Physician/Medical the the attending Box (IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 4 Pregnant at time of death 5 Other (specify) PO signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 No Division of Vital 1 Yes 2 No 1 TYAS the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death Check on o examiner's Hospital: 1 ☐ Inpatient Cther: 4 ☐ Nursing Home 5 ☐ esidence 6 ☐ Other (Specify) 1 Yes 2 No 2 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After 5 Pending Injury 1 Natural after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Patrick Shanahan, 31. Date filed (Month, Day, Year) State 13 Registrar

29b. Signature and title



MF

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

601

29d. Date signed Month, Day, Year)

			1 - For State Registrar	State of N	Marylan		artmen <i>rtificat</i>			ind Me		gien Reg N	006	00637
* * * * * * * * * * * * * * * * * * * *	Physici /Medic		1. Decedent's Name (First, Middle, Las Pearl	t)	Agne	S	Hof	fman			. Date of De. Month anuary		ay 2006 ear	3. Time of Death 4:48 P. M
	Examir		4a. Facility Name (If not institution, give Northampton Ma			re		Fred	Location of erick			4	c. County of Deat Free	derick
196	Funeral Director		5. Social Security Number 218-09-7938 6. S. Usual Residence of Decedent	9X 7 □M 21☑ F	Age (In yrs. 1	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min. OC	Date of Birt (Month, Da LODEL	^h 28 ^a ,	9. Birt	hplace (State or Foreign Maryland
	72 hours after death with the Maryland natural; or items 23a or 28e-f ahow dical Examir ar must be notified at	ector	10a. State 10b. County Maryland Frede	erick	10c. City	y, Town or La	Adam		n			10- 0		10d. Inside City Limits 1 Yes 2 No
	ath with t	Funeral Director	5101 Doubs Road				10f. Zip	2	171 0				itizen of What Co	•
9036	ours after de iral', or itema	by	11. Marital Status 1 □ Never Married 2 □ Married 3 ◯ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 ☐ Yes 2X If Yes, Give Year or Date	s?] No		Was Deced fYes, spec l□Yes		spanic Orig n, Mexican, Specify:	jin? (Speci , Puerto Ri	fy Yes or No- can, etc.)		14. Race - Ame Black, White Specify Whi	e, etc.
21215-0036		Completed	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12)		or 5+)		lent's Usua kind of wo DO NOT us naker	il Occupa k done d se retired)	tion uring most	of working			Kind of Business/ Vn Home	Industry
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than eumatic event, the Ma	To Be (17. Father's Name (First, Middle, Last) John L. O'Hara						Eliz	abeth	First, Middle, Murph	ny		
	as 1 and 2 should of Health and Mer litem 27 is marks r other treumatic		19a. Informant's Name/Relationship (7 Sharon A. Getzano			ghter	512	9 Do	ubs R	oad,	Adamst	r, City	or Town, State, 2 1, Maryla	and 21710
Baltimore,	00-		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	")	te Mt. ("Ceme	tery			2006	Fr	ocation - City or cederick	
Ball	permit. Page Depertment: importent: if any injury of		21. Signalure of Funeral Service Licen	· Dasfa	ra		106_	East	Chur	ch St	uneral reet,	Fre	ome ederick,	MD 21701
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. The	as a consequ	mme			, such as o			rest,		Approximate Interval Between Onset and Death
8760,	cate be executed by siclen and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to inimidiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	as a consequ		-							
.O. Box 6	The law requires that the death certifica tie has been signed by the attending ph tage 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcon 1⊟Live birth 4⊟Pregnant 9⊟ Unknown	2 Fetal at time of de	death 3	Ectopic pro						23d. Date of deli Month	very Day Year
rds, P	quires that in signed build be det	þ	Part II. Other significant conditions co	ntributing to death	but not resu	ulting in the ur	nderlying ca	use give	n in Part I.		23e. Did to		use contribute to	the cause of death?
Vital Records,		Completed	Atrine Fabr	itsilm	43					_	24a. Was a autop perfor 1 Yes	sy	prior to death?	topsy findings available completion of cause of
	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpa	tient 2 🗆	ER/Outpatien	3 DO	△ Othe			Check only or		6 □Other (Spec	.4.1
on of	ding After fune	tion: T	27. Manner of Death 1 SNatural 5 ☐ Pending	28a. Date of Ir		28b. Time of Injury		Bc. Injury Work		280	d. Describe h			ny)
Division	e Hospitel or Attending 24 hours after death. Funerel Director: After stely filled in by the fune	Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	289. Place of	Injury - At ho etc. (Specify	me, farm, stre			63 2 11		Location (S City or Tow	treet a n, Stat	nd Number or Ru e)	ral Route Number,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edicai C	29a. Certifier (Check only one) 1 Certifying Physical Example 2 Medical Example 1	ysician: To the be iner. On the basis and manner	of examinat	wledge, death ion and/or inv	occurred a restigation.	at the time in my op	e, date and nion, death	place, and occurred	d due to the d at the time, d	ause(s late an	s) and manner as d place, and due	stated. to the cause(s)
)	To the within 2 To the complete	¥	29b. Signature and title of certifier	Sless	atte	>		D56			1		ate signed (Month	**
_	6		30. Name and address of person who caroline Gessert	M.D., 6	10 Ni	nth Av		Bru	nswic	k, Ma	ryland	1 21	L 71 6	
	Sta Registr		31. Date filed (Month, Day, Year)	32 Regis	strar's Signat	ure	7							

00638

			For State Registrar	State of Mar		ertificate of			Reg. No.		
	Physici	an	1. Decedent's Name (First, Middle, Las	Ď.			HELM	2. Date of De Month	Day	Year	3. Time of Death 8:25 P M
	/Medic		4a. Facility Name (If not institution, give				n, or Location of De	NANUAN		200 (p	0/20 1 10
	LXaiiiii	eı	The Johns Hopkin			Balto		ity		,	
	Funeral Director		5. Social Security Number 6. Security Number 160–36–5441		(In yrs. last birtho	Months Da	ear If Under 24 H ys Hours M	in. 8. Date of Bir (Month, Da 1 2 / 1 2	th 1 943	9. Birthp Cour Dela	place (State or Foreigr ntry) Ware
and	À 11		Usual Residence of Decedent 10a. State 10b. County	1	10c. City, Town o	r Location				1	Od. Inside City Limits
Mary	in the part of the	to	PA Lancas	ter		Lanc	aster				1 ☐ Yes 2X No
th the	or 28e	Director	10e. Street and Number			10f. Zip Coo			10g. Citizen	of What Cou	ntry?
ath wi	23a d		151 Bender Mill	Road			17603		USA	<i>A</i>	
hours after deeth with the Maryland	ital hygiene. Id other than "natural", or items 23s or 28e-1 ehow event, i'ra Madical Examiner musi be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ② Divorced	12. Was Decedent Ev Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates 190	59–72	13. Was Decedent If Yes, specify (1 ☐ Yes 2 ☐	of Hispanic Origin? Cuban, Mexican, Pu No <i>Specity:</i>	(Specify Yes or No erto Rican, etc.)		lace - Americ lack, White, c <i>ify</i> : Whi	etc.
72 ho	lical	eted	15. Decedent's Ed (Specify only highest grad	ucation	16a. D	ecedent's Usual Oc	cupation	working		Business/In	•
d within 72 hours af	han "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		re. DO NOT use re nical Tec	one during most of v tired)	.o.m.y	Sub-con		
	Hygie thert int. Et		17. Father's Name (First, Middle, Last)	02	Crien	iicai iec		lame (First, Middle			ilici10
uld be		To Be	Charles P. H	e1m				Martin			
Maryland d 2 should be file	f Health and Mer Item 27 ie marke other traumatic		19a. Informant's Name/Relationship (7 Chris Helm /Son	ype, Print)			Street, C			vn, State, Zip 7512	Code)
permit. Pages 1 en	ent of Heal it: if item 2 y or other		20a. Method of Disposition 1 Burial 2 MCremation 3 4 Donation 5 Other (Specify		20b. Place of D	isposition (Name o		Date		n - City or To	own, State
permit.	Department of Important: If it any njury or one		21. Signature of Funeral Service Licen		lila	22. Name and Ad Harkins Fu	Idress of Facility neral Home,	Inc.,600 M	ain St.,	Delta, I	PA 17314
/	ysician Medical caminer		23a. P. n. Enter the disease, or comp s Jok, or heart failure. List only of lin me fale Cause (Final disease or condition resulting in death)	a Pneuv Due to (or as a	consequence of)			liac or respiratory a	rrest,		Approximate Interval Between Onset and Death
tificate be executed	physicien and s the burial-transit	ledical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Oue to (or as a c.	consequence of)		mic				2 years
The law requires that the death certifical	ned by the ettending ph deteched for use as ti	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at Iir 9 □ Unknown	Fetal death	3 □Ectopic pregn. 5 □ Other (specify				Date of delive	ery Day Year
quires that	s been signed t should be det	Ď	Part II. Other significant conditions co	ontributing to death but	not resulting in th	ne underlying cause	given in Part I.		obacco use c		ne cause of death? Dably 4 Unknown
or Attending Physicien: The law requires to	hes 3e 2	Completed						24a. Was auto perfo	ormed?	b. Were auto prior to co death? 1 \(\text{Yes}	psy findings available mpletion of cause of 2K No
Sien:	certificete rector, pag	Be	25. Was case referred to medicat examiner?				26. Place of D	Death (Check only			4,44,110
hysic	this co	မ	1 ☐ Yes 2 ☑ No	Hospital: 1 ☑ Inpatient		TIGHT 3 L DON		gHome 5□Res			y)
Attending Physicien:	leath. tor: After this certific the funeral director,	Certification:	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation			М	njury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe	how injury occ	curred	
ital or Att	irs after deati rai Director: led in by the	Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	y - At home, farm (Specify)	, street, factory, off	ice	28f. Location (City or To	Street and Nu wn, State)	mber or Rura	al Route Number,
he Hoep	within 24 hours after d To the Funeral Direct completely filled in by	Medical	29a. Certifier 1 I Certifying Ph (Check only one) 2 ☐ Medical Exam	ysician: To the best of niner: On the basis of e and manner state	xamination and/	leath occurred at the investigation, in r	e time, date and pla ny opinion, death o	ace, and due to the courred at the time,	cause(s) and date and place	manner as s e, and due to	tated. the cause(s)
Tot	To t	Σ	29b. Signature and title of certifier	A . 6		Ī	ense number		29d. Date sig		
			Den Sen Gy				5-000		Vanua	y 4.	2006
	D		30. Name and address of person who of Devi Sen Gupta, MD. 31. Date filed (Month, Day, Year)	John Hoy L	ins Hos	pital. 600	North wo	ife Street.	Baltin	nore, N	1D 21287

DHMH 17 Rev 1/2001

Registrar

			For Stata Registrar	State of	Marylar		artment of F		d Mental Hyg	giene	6	0063	39
	Physicia	210	1. Decedent's Name (First, Midd	fie, Last)				<u> </u>	2. Date of Dea	ıth	Year	3. Time of	Death
	Physicia /Medic		Carol	Mildred		all			JANUARY	2 200	6	1821	М
	Examin	er	4a. Facility Name (If not institution MEMORIAL HOS		oer)		4b. City, Town, o		ath	4c. County of			
	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs.	. last birthday)	If Under 1 Year Months Days	If Under 24 H	rs. 8. Date of Birt		9. Birth	olece (State or	r Foreign
	Director		220-40-2245	1□M 2√F	63	Yrs.	Months Days	Hours M	in. 8. Date of Birt. (Month, Day Dec 24	, 1942	Coui	WID	
	land ow	1	Usual Residence of Decedent 10a. State 10b. Count	у	10c. C	ity, Town or Lo	cation				1	IOd. Inside Cit	y Limits
	Mary Miled	tor	MD Alle	gany		Rawli	ngs					1 🗆 Yes	2□No
	or 28	Olrec	10e. Street and Number		· · · · · · · · · · · · · · · · · · ·		10f. Zip Code			10g. Citizen of W		ntry?	
	sath w	rai	22126 McMulle	n Highway	ant Francis I	16 101		21557	/C# - W N -	US			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Items 23a or 28e-f show minipolent: If Item 27 is marked other then "netural; or Items 23a or 28e-f show minipolent: If item 27 is marked other then "set on the Transfer or 27 is marked or 28	by Funeral Director	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	Armed Forc	es? No		was Decedent of H f Yes, specify Cuba I ☐ Yes 2 No	an, Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)	Specify:	, White,		
2-0	72 hou			nt's Education est grade completed)		16a. Deced	lent's Usual Occup	ation	vorkina	16b. Kind of Bus			
121	vithin ne. hen "	Completed	Elementary/Secondary (0-12)	College (1-4	lor 5+)	life. L	DO NOT use retired	d)					
d 2	filed v Hygie other f		12 17. Father's Name (First, Middle	, Last)		Disable	2 u	18. Mother's N	lame (First, Middle,	none Maiden Sumame	9)		
Maryland 21215-0036	nould be I Mental narked o	To Be	Samuel Timb			10: 11:00			ia (Spenc				
Ma	ith and 2 st lith and 27 is r		19a. Informant's Name/Relation Linda Durst		ighter		bury Aver		Rural Route Numbe			21502	2
re,	of Healifem		20a. Method of Disposition	· · · · · ·	20b.	Place of Dispo	sition (Name of natory or other place		Date	20c. Location - 0	City or To	own, State	
imo	Pages ment of I ent: If its ury or o		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (neral Home		1/6/2006	Cresapt	own	M	D
Baltimore,	permit. Departr Import any inj		21. Signature of Firmeral Service	Licensee M	W	22	Name and Addre Scarpell		Home, PA ue: Cumberl	and MD 2	1502		
			23a. Part . Enter the disease, of heart failure. Lis	or complications that caust only one cause on each	used the dea th line.	th. Do not ente	er the mode of dyin	ng, such as card	liac or respiratory ar	rest,	1002	Approximate Interval Betw	veen
	Priysician		Immediate Cause (Final disease or condition resulting in death)	a Coro	nary .	Artery	Disease					Onset and D 5 year	S
	/Medical Examiner		, southing in doubly	Due to (or	r as a conse	quence of):							
	Sett	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or	r as a conse	quence of):							
1	acuted ind transil	Examlne	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C									
8760,	cate be executed physician and the burial-transit		sesuring in death) cast	Due to (or	as a conse	quence of):					15		
687	ficate physics the	edlcal		d	-								
Вох	death certific e attending p d for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregn		Ectopic pregnancy			23d. Date	of delive	ery	
	0 0 0	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nt at time of		Other (specify)	<u> </u>		Mon	th	Day Y	ear
P.0	that the ed by detach	h h	Part II. Other significant condit	ions contributing to dea	th but not re	sulting in the ur	nderlying cause giv	en in Part I.	23e. Did to	bacco use contri	bute to th	ne cause of de	ath?
rds,	og Ded	d by							1 🗆 Y	es 2 🗆 No	3 🗆 Prob	abiy 4 ⊠Ü	nknown
Record	aw s b	ompleted							24a. Was a		ere auto	psy findings a	vailable
R	. o c o	Com							autop perfor	med? de	eath?	mpletion of ca 2□ No	use of
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medic examiner?			2	011		eath (Check only or	10)			
of	Phys rthis ral dii	. To	1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Ing	-	ER/Outpatien 28b. Time of		4 🗆 Mulsing	Home 5 ☐ Resid	ence 6 Othe		y)	
ion	Attending Phore death. ector: After this by the funeral.	atlor	1-Natural 5 ☐ Pend 2 ☐ Accident inves		Day Year)	Injury	28c. Injur Wor M 1	k? Yes 2∐No					
Division	el or Atte s after dea of Directo	Certification:	3 Suicide 6 Could 4 Homicide deter	mined 286. Place of	f Injury - At I	nome, farm, stre ify)	eet, factory, office		28f. Location (S City or Tow	treet and Numbe n, State)	r or Rura	l Route Numb	er,
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	ledical (29a. Certifier Certify (Check only 2 Medice	ing Physicien: To the b I Examiner: On the bas and manne	is of examin	owledge, death ation and/or inv	occurred at the ting restigation, in my o	ne, date and pla pinion, death oc	ce, and due to the occurred at the time, o	ause(s) and man late and place, a	ner as si	ated. the cause(s)	
	To ti To ti comp	M	29b. Signature and title of certific	er//			29c. Licens		2	9d. Date signed	(Month,	Day, Year)	
)			1/1	/ /			D36	/66		JANUARY	6,	2006	
	2		30. Name and address of person					MD 215	02				
	Sta	te	Dr. Vik Poonai 31. Date filed (Month, Day, Yea	1 00.0	Carredo Cina			<u> </u>	U 4				
	Registr		JAN 13	2006	we I	K. A							

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			1. Decedent's Name	(First, Middle, Las	st)					2. Date of De	ath Day	Yeer	3. Time of Death
	Physicia /Medic				Dorothy	Carrie	Hess	ong		JANUAR		2006	4:00 A
	Examin		4a. Facility Name (If					4b. City, Town,	or Location of Death		4c. Co	unty of Death	
			RAVENWOOD					HAGERST		,		SHINGTO	
	Funeral Director		5. Social Security Nu 236-28-608		ex 7.Ag. □M2XIF	e (In yrs. last t 89	Yrs.	Months Days		8. Date of Bir (Month, Da Decembe	y, Year)	6 9. Birthp Cour West	olace (State or Foreigntry) Virginia
	yland		Usual Residence of (10a. State	10b. County		10c. City, To	own or Loc	ation				1	0d. Inside City Limit
	Man.	to	Maryland	Washing	ton		Si	nithsbur	a				1 ZYes 2 □ N
	h the	irec	10e. Street and Num					10f. Zip Code			10g. Citizen	of What Cour	ntry?
	th wit	aiD	52-A No	rth Main	Street			21	783		Ü	S.A.	
98	s 1 and 2 should be filed within 72 hours after death with the Maryland Fleath and Mental Hygiene. Itam 27 Is marked other then "natural", or Itams 23a or 28a-f show other traumatic event, the Madical Examinatment by nutified at	y Funeral Director	11. Marital Status 1 ☐ Never Marrie		12. Was Decedent Armed Forces? 1 ☐ Yes 22☐ I If Yes, Give			Vas Decedent of Yes, specify Cut	Hispanic Origin? (Spoan, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		Race - Americ Black, White, ecify:	etc.
8	ural',	d by	3X☐ Widowed 4		Year or Dates:							wn	ite
15-	"nat	lete	(Specif	 Decedent's Ed fy only highest gra 	lucation de completed)	16	Sa. Deced (Give I	ent's Usual Occu kind of work done	ipation e during most of work ed)	ing	16b. Kind (of Business/In	dustry
21215-0036	should be filed within and Mental Hyglene. s marked othar than "umatic event, ir a Men	Completed	Elementary/Secon 5	dary (0-12)	College (1-4or 5	5+)		nemaker	<i>50)</i>		Ноп	ne	
	e file al Hyg othe vent,	Bec	17. Father's Name (F	First, Middle, Last)					18. Mother's Nam	e (First, Middle	, Maiden Sui	тате)	
<u> a</u>	should b nd Mente marked umatice	P	James	M. Cleg	I				Jess.	ie M. M	anuel		
Maryland	2 sho and I Is me		19a. Informant's Nar	me/Relationship (Type, Print)	15	9b. Mailin	g Address (Stree	t and Number or Rur	al Route Numb	er, City or To	owe, State, Zip	uCode)
	1 and 2 Health am 27 I		Paul E. He		Stepson)				St. Smit				
altimore,			20a. Method of Dispo		Removal from State	ceme	tery, crem	sition (Name of natory or other pla	ace) Janua	Date ary 9,	20c. Locati	ion - City or To	own, State
Ë	. Pag iment tant:	3	` 4 □Donation	5 Other (Specify	y)	Smith:		<i>Cemete</i>		006	Smi ths	burg,	Maryland
Bal	permit. Page Depurtment of Important: If any njury or once.		21. Signature of Fun	neral Service Licer		0011111		Name and Addr	•				ral Home
ì			23a. Part1. Enter the	e disease, or com	plications that caused	the death. D			bury Ave.			Maryia	Approximate
ı	Dhusisian		Immediate Cause (F	Final	one cause on each li		0000	a loil	00000				Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		a. TCU	a consequence	e off:	in from	we			aphing)	1 Moult
Į.	Examiner				CONIC	aconsequence	01).	dear	Dailen	e			Venelli
		Jer	Sequentially list con if any, leading to im- cause. Enter Under	ditions, mediate	Due to (or as	a consequence		racca					1 1000000
V	cuted nd ransit	Examiner	that initiated events	njury	C.								
oʻ	e exectant ar		resulting in death) L	ast	Due to (or as	a consequenc	e ol):						
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	cian/Medical		•	_d								
	e as	Med	IF FEMALE:										
Вох	ath c	ian	23b. Was decedent in the past 12 r		23c. If yes, outcome	2 Fetal dea		Ectopic pregnan	су		23d	 Date of delive Month 	ery Day Year
	the a	Physic	1 ☐ Yes 2 ☐ 9 ☐ Unknown		4□Pregnant a 9□Unknown	time of death	5	Other (specify)					
P.0	that the ed by	/ Ph	Part II. Other signific	cant conditions	contributing to death b	ut not resulting	g in the ur	iderlying cause g	iven in Part I.	23e. Did 1	tobacco use	contribute to t	he cause of death?
of Vital Records,	w requires that the deben signed by the should be detached	d by								1 🗆	Yes 2□N	to 3 Prot	pably 4 Unknow
CO	w req	Completed								24a. Was	an 2	4b. Were auto	psy findings availab
Re	The lav	omo								auto perfe	psy ormad?	prior to co death?	mpletion of cause of
<u>la</u>		a	25. Was case referr	ed to medical					26. Place of Deat	1 Yes	20 No	1 🗆 Yes	2 No
5	Physician: this certificantal director,	To B	examiner?		Hospital:	ent 2□FR/	Outpatien	3 DOA 0	ther: 4 ursing Ho			Other (Specia	5(1)
10	Attending Physician: r death. ector: After this certific by the funeral director.		27. Manner of Death	1	28a. Date of Inju	ırv 28t	o. Time ol Injury	28c. Inju	ury at	28d. Describe	how injury or	ccurred	,,
ior	Attending F death. ctor: After y the funer	atio	1 Natural 22 Accident	5 Pending investigation		ly rear/	Hijury		Yes 2 No				
Division	To the Hospital or Attendi within 24 hours effer death. To the Funaral Director: A completely filled in by the fu	Certification;	3 Suicide 4 Homicide	6 Could not be determined	280. Place of in	jury - At home, tc. <i>(Specify)</i>	, larm, stre	eet, lactory, office	•	28I. Location (City or To	(Street and N wn, State)	lumber or Rur	al Route Number,
	Hospit	edical (29a. Certifier (Check only one)	Certifying Ph Dedical Exam	nysician: To the best niner: On the basis of and manner st	f examination	dge, death and/or inv	occurred at the restigation, in my	time, date and place, opinion, death occur	and due to the red at the time,	cause(s) and date and pla	d manner as s ace, and due to	tated. the cause(s)
	To th To th comp	Me	29b. Signature and	title of certifier	0 1	1			nse number			igned (Month,	Day, Year)
			1	langa	1 1/80	red !	_		D28365			1 - 6-0	6
•	OF.		30. Name and addre	arson who	complete cause of	death (It) 23	а) (Туре.	Print)	C1 /- i	1			,
_	8		MA	N2AL	25/49	Pr (368	nuels	028365 Street 19	Lagesta	in 19	0 2	1740

DHMH 17 Rev 1/2001

State

Registrar

M AN 2 AL 31. Date liled (Month, Day, Year)

JAN 1 3 2006

HESSONG, Dorothy Carrie

	ľ	1 - State of i	Maryland		irtment of H tificate of I		Mental Hy	rgiene Reg: No. 0 6	00641
Physicia	an .	Decedent's Name (First, Middle, Last)					2. Date of De Month	eath Day	3. Time of Death
/Medic Examin	al	Charles William 4a. Facility Name (If not institution, give street and numb	Hugh	nes	4b. City, Town, or	Location of De	Januar	4c. County of	
		Citizens Care & Rehabil			Freder				ederick
Funeral Director		5. Social Security Number 6. Sex 7. 15 M 2 F	Age (In yrs. Ia	est birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H	8. Date of Bi (Month, Da April	14, 1938	9. Birthplace (State or Foreign Country) Maryland
and		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
a-f eho	ctor	Maryland Frederick	Fre	derick	ζ				1 Yes 2 No
th with the	al Director	10e. Street and Number 1900 Rosemont Ave.			10f. Zip Code 217	02		10g. Citizen of Wh	at Country?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or Items 23a or 28a-f show eny injury or other traumatic event, the Mudical Examples invested colling an once.	by Funeral	11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced 12. Was Decede Armed Force 1 Yes, Give Year or Date	as? ∑ No	l:	Vas Decedent of H f Yes, specify Cuba I ☐ Yes XXNo	ispanic Origin? in, Mexican, Put Specify:	(Specity Yes or Netro Rican, etc.)	Black,	American Indian, White, etc. White
within 72 ho iene. r then "netur	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) College (1-4	or 5+)	(Give life. L	lent's Usual Occup kind of work done OO NOT use retired m Hand/L	during most of w f)	rorking	16b. Kind of Busi	
should be filed ind Mental Hyg marked other umatic event,	To Be C	17. Father's Name (First, Middle, Last) William S. Hughes					ame (First, Middle len L. P	a, Maiden Sumame, eyton	,
and 2 shou ealth and M n 27 le mar ier traumati	-	19a Informant's Name/Relationship (Type, Print) Mrs. Naomi Lovato, sistem						derick, M	
Pages 1 a ment of Hes ant: If item ury or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from St. 4 ☐ Donation 5 ☐ Other (Specify)	CB	metery, cren	sition (Name of natory or other place et Cemetery	Jan. 7	, 2006		ity or Town, State .ck, Maryland
permit. Departr Imports eny inj		21. Signature of Funeral Service Ligensee	M002	22	Keeney a 106 East	hd Basf Church	ord PA F St., Fr	uneral Ho ederick,	ome MD 21701
Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on eac Immediate Cause (Final disease or condition resulting in death) Due to (or	sed the death h line. as a consequ	ráti	-	ig, such as card		arrest,	Approximate Interval Between Onset and Death
cate be executed physicien and sthe burial-transit	dicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c	as a consequ						
Attending Physician: The law requires that the death certific rideath. ector: After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as	Physician/Med		n 2 ☐ Fetal It at time of de	death 3	Ectopic pregnancy Other (specify)	,		23d. Date Mont	· ·
res that igned by	by	Part II. Other significant conditions contributing to deal	th but not resu	Iting in the u	nderlying cause giv	en in Part I.			oute to the cause of death?
e law requii has been s je 2 should	Completed	Abstruction, Ch	rom	arz	Stuce	there	24a. Was	s an 24b. We	Probably 4 Unknown Bre autopsy findings available or to completion of cause of
ician: The lav certificate has rector, page 2	0	Dulmanay disea	De A	asto	ostom	26 Place of D	leath (Check only	250 1 E	ath? ☐Yes 2☐ No
Physician: this certific at director.	ToB			ER/Outpatien		er: 4 🔀 Nursing	Home 5 ☐ Res	idence 6 Other	
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ital or A	Certif	4 Homicide building	, etc. (Specify)			City or To	own, State)	
To the Hospital or Attendi within 24 hours atten death To the Funeral Director: I completely filled in by the fa	Medical	29a. Certifier (Check only one) Certifying Physician: To the base one) and manne	is of examinat	wledge, death ion and/or in	vestigation, in my o	pinion, death oc	ice, and due to the curred at the time	, date and place, ar	id due to the cause(s)
To To con	-	29b. Signature and tiple of certifier	ent to	Lh.	29c. Licens	3578	3	An 11/2	(Month, Day, Year)
5		30. Name and address of person who completed cause	of death (Item	23a) (Type,	Print)	st 00	KST 1	Fale	rick MD
Sta Registi		31. Date filed (Month, Day, Year) 32. Her	gistrar's Signat	ture	ade				

		1 - State of Marylar State of Marylar		rtificate of L			Reg. No.	Jb	0064
Dhysia		1. Decedent's Name (First, Middle, Last)				2. Date of De Month	ath Day	Year	3. Time of Deat
- Physici /Medi		Bertha Caroline Harrison				JANUAR		06	2:55a
Examir	ner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or		1		ty of Death	•
	1	St. Mary's Hospital		Leonar		1		Mary	
- Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.		Months Days	Hours Min.	8. Date of Bir (Month, Da	th ly, Year)	Cou	
Director		217-26-8731 Usual Residence of Decedent	75 Yrs.			8-4-19	30	Mary	land
/land			ty, Town or Lo	cation				1	IOd. Inside City Lin
Mar.	tor	Maryland St. Mary's Ho	11ywoo	d					1 Tes 2
h the	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of	What Cour	ntry?
th wit	alD	43701 Ferguson Road		20636			United	Stat	es
ame ame	Funeral	11. Marital Status 12. Was Decedent Ever in U		Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Si	pecify Yes or No		ace - Amendack, White,	
or it	y Fu	1 Never Married 2 Married 1 Yes 2 No		1 ☐ Yes 2 🖥 No	Specify:	,,	Spec	ifv	
ural',	d by	3 Widowed 4 Divorced Year or Dates:						Wn	ite
n 72	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	turing most of wor.	king	16b. Kind of	Business/In	dustry
withir ene. then	mc	Elementary/Secondary (0-12) College (1-4or 5+)		ookkeeper			Reta	ai1	
filled Hygir ther	Ö	17. Father's Name (First, Middle, Last)		OURREEPCI	18. Mother's Nan	ne (First, Middle	, Maiden Suma	ıme)	
d be ental ked c	To Be	Edward Linton Kelly		,	Rose Ma	rie Bor	leis		
should Man	1	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street a	and Number or Ru	ral Route Numb	er, City or Tow	n, State, Zip	Code)
nd 2 lith a 27 is		Diane Higgs/Daughter	4370	1 Ferguso	n Road,	Hollywo	od, MD	20636	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or iteme 23s or 28s-1 ehow any folloy or other traumatic event, the Modical Exertine, mark be inclified at once.			Place of Dispo	sition (Name of matory or other place	ا اه	Date	20c. Location	- City or To	own, State
Page ient o nt: if ry or		1 Medi Burial 2 U Cremation 3 U Hemoval from State	•	n Memoria	1	2006	Great	Mills	, MD
mit.		21. Sanature of Funeral Santice Licensee	0	. Name and Addres			d Funer	al Ho	me, P.A.
P P P P		Edward N. Brinsfield, Jr. M000)52 2	2955 Но11	ywood Ro	ad, Leo	nardtow	n, MD	20650
Physician and Makician and Makician and Italiansi the prival-transit	Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consection of the condition of the cause). Due to (or as a consection of the cause).	quence of): OBSTA quence of): PESEC			m idi	renst		Interval Betwee conset and Dea DAYL YEARS DAYS
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N S S	Completed					24a. Was		. Were auto	psy findings ava
o	Eo					auto perfo	rmed?	death?	mpletion of caus
iician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?			26. Place of Dea				
d is	10] ER/Outpatier	nt 3□ DOA Othe	er: 4 Nursing H	ome 5 ☐ Resi	dence 6 🗆 O	ther (Specif	y)
or Attending Physician: after death. Director: Atter this certific in by the funeral director,		27. Manner of Death 1 Natural 5 Pending (Month, Day Year)	28b. Time o Injury	28c. Injury Work	at (?	28d. Describe	how injury occu	ırred	
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spital ours al									
Fur F	edlcai	29a. Certifier 1 Certifying Physician: To the best of my kno (Check only one) 2 Medical Examiner: On the basis of examination one)	owledge, deat ation and/or in	h occurred at the tim vestigation, in my op	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and n date and place	nanner as s , and due to	tated. the cause(s)
and and and and and and and and and and	Mec	one) and manner stated. 29b. Signature and title of certifier		29c. License	number		29d. Date sign	ed /Month	Day Vear
To Too		12/6rie	MD		12096		_	-06	
		V (U -		- V	760-16		1 ~		
		 Name and address of person who completed cause of death (Iter 	n 23a) (Type,	Print)					
		DR. RAJBINDER GILL POST OFFI		•	LYWOOD, 1	MADSET ANT	20636	2	

Tamara Hynes 06-0054 dl

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

_			For State Registrar			Marylan				ealth a			Reg. No	ODI)	006	43
	Physicia	an	1. Decedent's Name (First, I	^{Middle} , Last) Michel		nes						2. Date of De Month		y 2006	'ear	3. Time o	
	/Medic	al	4a. Facility Name (If not inst					4b. City	Town, or	Location o		Januar		. County of		2:34	P "
	Examin	er	Union Hospi	_		,			cton					ecil			
	Funeral Director		5. Social Security Number 214-15-8454	6. Sex	M 2 X F	7. Age (In yrs. 18	last birthday) Yrs.	If Unde Months	r 1 Year	If Under 2 Hours	Min	8. Date of Bi (Month, D) Apr.	th	1 0	Birthp Coun Mar	lace (State try) yland	or Foreign
	land ow		Usual Residence of Decede 10a. State 10b. Co			10c. Cit	y, Town or Lo	cation							1	0d. Inside (City Limits
	Mary I-f sh	tor	MD C	ecil		Pe	erryvil	le								1X Ye	s 2 No
	th the	lrec	10e. Street and Number	,	-			10f. Zi	Code				10g. Ci	tizen of Wh	at Coun	try?	
	ath wi	rai	724 Broad						21903					J.S.A.			
396	n 72 hours after death with the Maryland "neturel", or Iteme 23e or 28a-f show jedical Examinat must be notitled at	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 3 □ Widowed 4 □ Div	Married	12. Was Dece Armed For 1 ☐ Yes If Yes, Giv Year or Da	2 [X]No e		Was Dece f Yes, spe 1 ☐ Yes		spanic Orig n, Mexican Specify:	gin? (Spec , Puerto F	cify Yes or No Rican, etc.)	>-	14. Race - Black, Specify:	White,	etc.	
200	72 hor	ted	15. Dec (Specify only)	edent's Edu			16a. Dece	dent's Usu	al Occupa	ation during most	of workin	10	16b. K	ind of Busi	ness/Ind	lustry	
121	c <u>B</u>	отріє	Elementary/Secondary (0		College (1	-4or 5+)	life.	<i>make</i>	ise retired)	OF WORKE	<i>,</i> 9	Ir	n home	9		
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	and 2 should t eaith and Ment m 27 is marked ner treumetic e		19a. Informant's Name/Rela Robert G. Hy			sband)		-				Route Numb				Code) 2190	3
Baltimore,	permit. Pages 1 an Department of Heal Important: if Item 5 eny Injury or other ance.		20a. Method of Disposition 13☐6urial 2 ☐ Crema 4 ☐ Donation 5 ☐ Ott		lemoval from S	State	Place of Disponentery, cremetery,	natory or	other plac		_{ام} 1/6/0	ate)6		ocation - Ci deen			d
Balt	permit. Departr Imports eny Inje		21. Signature of Funeral Se	Ame	1.Un	onles.						ral Ho		P.A.			
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	res thet the signed by I be detact	٥	Part II. Other significant co	onditions co	ntributing to de	ath but not res	sulting in the u	nderlying	cause give	en in Part I.		1		use contrib			
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Division	iel or Atts s effer des al Director ad in by th	Certification;		Could not be determined	28e. Place buildi	of Injury - At h ng, etc. <i>(Speci</i>	iome, farm, sti fy)	reet, facto	ry, office		2	8f. Location (City or To	Street ai wn, Stat	nd Number e)	or Rura	l Route Nu	m <i>ber,</i>
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			30. Name and address of p	erson who co	ompleted caus	of death (Ite	m 23a) (Type		CME				Janu	ary 3	3, 2	006	
			ZABILL	lAt	1-1	3			Peni	n Stre	eet,	Baltim	ore,	Mary	/lan	d 21.	201
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	1 - For State Registrar		State of	Maryland /	Departme Certifica			and M		jiene	06	00644
	1. Decedent's Name	(First, Middle, Last	")						2. Date of Dea Month	th	V	3. Time of Death
Physician /Medical		LESTER		WARD	H	ICKS			Month	Day 5	2006	505 AM
Examiner	4a. Facility Name (If I					, Town, or	Location of	of Death		4c. Co	unty of Death	
	Upper C					a 1 Vana		Ai			Harf	
Funeral Director	5. Social Security Nur 215-14-8		X M 2□F	Age (In yrs. last i	Yrs. Months	Days	If Under Hours	Min.	8. Date of Birth (Month, Day 9/25/1	Year)	9. Birth	place (State or Foreign
Mector	Usual Residence of D	_,_	a.	0)			1		9/20/1	.922	Me	aryland
show of at		10b. County		10c. City, To	wn or Location							10d. Inside City Limits
el, or items 23a or 28a-f sho Ever it et mast be radified at by Funeral Director	MD.	Harfo	rd				Fore	est	Hill			1 ☐ Yes 2 X No
or 28	10e. Street and Numb	ber			10f. Z	ip Code			1	0g. Citizen	of What Cou	intry?
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by F	1 ☐ Never Married 3 ☐ Widowed 4		1 Yes 2 If Yes, Give Year or Dat	5.59.8 TO 5	T 1□ Yes	2 No	Specify:			Sp	ecify: TA	White
		15. Decedent's Edi			ia. Decedent's Us	ual Occupa	ition			16b. Kind o	of Business/Ir	
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Be (irst, Middle, Last)					18. Mothe	r's Name	(First, Middle,	Maiden Sur	name)	
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5		Cremation 3 🔲		ate ceme	tery, crematory or	other place	´ l			20c. Locati	on - City or T	own, State
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eny injury or other tr once.	21. Signature of Fund	eral Service Licens	5/	111	22. Name a							aryland
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•	shock, or heart Immediate Cause (F	lailure. List only o	ne cause on ea	ch line.		Ta		r		931,		Interval Between Onset and Death
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dicai			d									
n/Medic	IF FEMALE:		00. 11							I		
Completed by Physician/Me	23b. Was decedent a in the past 12 m	nonths?	1 ☐Live bir	ome of pregnancy th 2 Fetal dea						23d.	Date of deliv Month	ery Day Year
ysic	1 Yes 2 9 Unknown	No	4∟Pregna 9□ Unknov	nt at time of death vn	5 🗌 Other (s	pecify)						54, 104.
/ Physicia	Part II. Dther signific	ant conditions co	ntributing to dea	th but not resulting	in the underlying	cause give	n in Part I.		23e. Did to	pacco use o	contribute to t	the cause of death?
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To Be C	1 Yes 2 X		Hospital:	patient 2 ER/6	Outpatient 3 🗆 🗅	Othe	-		Check on on		Othor (Cassi	5 .)
n: T			28a. Date of		. Time ol	28c. Injury	at	-	8d. Describe ho			197
atio	1 Natural 2 Accident	5 ☐ Pending investigation		Day (ear)	Injury M	Work¹ 1 □ Y	es 2 1	No				
Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	280. Place d	f Injury - At home, g, etc. (Specify)	larm, street, lacto	ry, office		2	8f. Location (Si City or Town	reet and No	ımber or Rura	al Route Number,
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ely fil	29a. Certifier 1 (Check only 2	Certifying Phy Medical Exam	rsician: To the b	est of my knowled is of examination	ge, death occurred	d at the time	e, date and	d place, a	nd due to the c	ause(s) and	I manner as s	stated.
completely filled in by the funeral	one) 29b. Signature/and W		and manne	r stated.		c. License						
8	250, Signature and	aman	oto	MD	25		_) =	2	ad. Date si	gned (Month,	uay, rear)
3	20 N	<i>J</i>				Dog	122.	12		1- 6	5 20	006
7	30, Name and address	ss of person who d	UNIO	ui death (Item 23a	I) (Type, Print)	hoso	DON	4 1	m . 7	Rol.	no in	иЛ
State	31. Date filed (Month	n, Day, Year)	32. Re	gistrar's Signature	replace C	, we see	parcik	e t	,	Jr. 1 /	TLY //	1 U
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HCKS, Lester

State of Maryland / Department of Health and Mental Hygienen Certificate of Death Reg. No. 2 Date of Death 3 Time of Death . Decedent's Name (First, Middle, Last) **Physician** 1:46 AM HAWTHORNE JANUARY MARGARET LYNCH 1, 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WASHINGTON REEDERS MEMORIAL HOME **BOONSBORO** If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🛛 F Yrs. 214-09-7630 MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City. Town or Location. 10b. Count 28a-f show other traumatic event, the Modical Examiner must be notified at 1 XYes 2 ☐ No Director MARYLAND WASHINGTON BOONSBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 21713 141 SOUTH MAIN STREET U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Maryland 21215-009 þ 3 X Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 10 SWITCHBOARD OPERATOR SHOE MANUFACTURE Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked any injury or other traumatic eventages. HARRY L. WEAVER MARY E. LYNCH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ROBERT L. HAWTHORNE/SON 1315 ATLAS LANE, NORTHAMPTON, PENNSYLVANIA 18067 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BOONSBORO CEMETERY 01/06/2006 BOONSBORO, MARYLAND 22. Name and Address of Facility 21. Signature of F 7606 Old National Pike Paul M. Dean BAST FUNERAL HOME Boonsboro, Maryland 21713 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, arcomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final neumoma **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner use as the burial-transit requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2X No 1 Yes Hospital or Attanding Physician: After this certific funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. ZAFAR MALIK, 20311 LAPPANS ROAD, BOONSBORO, MD 21713/301-432-8470 31. Date filed (Month, PANY 0 3 2006 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Year Richard Paul Keller 1:00 AN 01 01 06 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Cumberland sacred Allegany Hear 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1949 Days Hours 219-54-1673 XXM 2 F 56 Director Maryland Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location oriant: if itam 27 is marked other than "natural", or itams 23s or 28s-4 show injury or other traumatic event, Its Madigal Examinar must be notified at 10d. Inside City Limits WV. Mineral Keyser Director 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1510 United States Terri St. 26726 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2X Married 1 XYes 2 No. If Yes, Give Vietnam Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Paper Manufacturer Winder Operator 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ouid be f permit. Pages 1 and 2 should be Department of Health and Menta Important: If itam 27 is marked eny injury or other traumatic evons in. Wilson E. Keller SR Ethel Herrell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Keller/ wife 1510 Terri St, Keyser, West Virginia 26726 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 01/04/ 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removat from State Westernport Maryland 4 □Donation 5 □Other (Specify) Philos Cemetery 2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home 111 Church St, Westernport, Maryland 21562 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SMALL CELL CARCINOMA HEAD AND NECK Immediate Cause (Final **Physician** OCT 2004 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine use as the burial-transit Due to (or as a consequence of). ate has been signed by the attending physician page 2 should be detached for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 No 1 ☐ Yes 2.2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 1 ☐ Yes 2 ØNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending 24 hours after death. Funeral Director: A 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 24 To the within 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00 23371 Name and address of person who completed cause of death (Item 23a) (Type, Print) 54VA Johnson Heights, Cumberland, Md. 21502 Zaman 625 Kent Jamar avenue 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 3 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar			partment of Fertificate of			Reg. No.	006	00647
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	CAGIIIII	iei	474 Fort Avenue			Cumber				legany	
	Funeral Director		5. Social Security Number 6. S 216-14-1172		(In yrs. last birthda 81 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs Hours Min		db	O Diet	nplace (State or Foreign untry)
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	or 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citiz	zen ol What Co	untry?
	aath w	rai	474 Fort Avenue	12. Was Decedent E			21502			USA	
	parmit. Pages 1 and 2 should be filed within 72 hours attar death with the Maryland Department of Health and Mantle Hygiene. Department of Health and Mantle Hygiene. Important: if them 27 is marked other than "natural; or teme 23s or 28s-f show eny injury or other traumatic event, the Modical Examinar must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 Note that Yes, Give Year or Dates:		I. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	an, Mexican, Puer Specify:	specify Yes or N to Rican, etc.)	1	14. Race - Ame Black, White Specify: Wh	e, etc.
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yla	d Mant marked matic	2	Edward George			iling Address (Street		D. Klost			To Code
5	and 2 s faalth an m 27 ie r her traur		Debbie Vinci	daugi	nter 614	4 Montgom	iery Aven	ue Cum	berlaı	nd ————	MD 21502
	Pages 1 mant of H ant: if Ite ury or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		20b. Place of Dis cemetery, ci St. Mary's	ematory or other place	ce)	1/6/2006		mberlan	77.
	parmit. Daparti Import eny inj		21. Signature of Funeral Service Licen	see ///	11	22. Name and Addre					
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ń	res tha igned ba del	ρ	Part II. Other significant conditions o	ontributing to death bu	t not resulting in the	underlying cause giv	ren in Part I.				the cause of death?
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	ding P h. Aftar I funare	tion:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year) 28b. Time Injury	Wor	yat rk? Yes 2 ⊡No	28d. Describe	how injury	occurred	
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	To the Hospital or Attending Physicien: The law raquires that the death cartit within 24 hours attended: The Punatai Directora: The complexed Directora: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier TS Certifying Ph (Check only 2 Medical Examone)	y sician: To the best o niner: On the basis of and manner stat	examination and/or	ath occurred at the til investigation, in my o	me, date and plac opinion, death occ	e, and due to the urred at the time	cause(s) a date and	and manner as place, and due	stated. to the cause(s)
	withir To th comp	¥	29b. Signature and title of certifier		//	29c. Licens	1.7			signed (Monti	
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	4		30. Name and address of person who			e. Print) Seton Driv	o Cumbo	rland M	D 215	02	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00648 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 0 0 6 Year Jannth . **Physician** 2, Mary Kathern Kamauf 9:30 P M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frostburg Allegany 11310 Upper Georges Crk Rd If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | NOV | 20 Open | 9 2 4 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖫 F 215-20-7494 81 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other then "neturel", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "neturel", or items 23a or 28a-f show MD Allegany Frostburg 1 ☐ Yes 2 No Directo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 11310 Upper Georges Crk Rd 21532 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bobbins Stores Dept. Textile 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Edward Metzner Vada Marie (Dickens) Metzner 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Richard Kamauf Husband 11310 Upper Georges Creek Rd, Frostburg MD 20c. Location - City or Town, St 21532 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition ₩ Burial 2 Cremation 3 Removal from State ö permit. Pag Department important: i eny injury o Sunset Mausoleum Jan 5 2006 Cumberland, 22. Name and Address of Facility Hafer Funeral Service, P. LaVale. MD 21532 ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenspe Douglas 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARCINOMA METSTATIC About /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate outco. Enter or Jordy by Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After t Natural Accident 5 Pending Injury 1 Tyes 2 No investigation Director: the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Direct 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29b. Signature and title of certifier 29c. License number

State Registrar 31. Date filed (Month, Day, Year) JAN 1 0 2006

HARJIT S.

Sidh

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



ORIGINAL

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BISHOP WALSH BO CUMBERLAND, MD 21502

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	61	W.	5. Social Security Number 6. Sex	HUSUI	(In yrs. last birthda)	If Under 1 Year	If Under 24 Hrs.	8 Date of Birth	FILEGO	thplace (State or Foreign
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the N	28a-f	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
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ital	tificati	Be Co	25. Was case referred to medical				26. Place of Deat	1 ☐ Yes		s ZZ No
of V	his ce I direc	ToE	examiner? 1 Yes 2 No		nt 2 ER/Outpat	IGHT 3 LL DOA			dence 6 Other (Sp.	ecify)
Division of Vital Records, i or Attending Physicien: The law requires t	After t funera	lon:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y Year) 28b. Time Injury	Wo	ry at rk?]Yes 2 □ No	28d. Describe i	now injury occurred	
/ISIC	ctor:	flcat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Inju	ury - At home, farm,	street, factory, office	1103 2 2 3 1 1 2	28f. Location (S	Street and Number or F	lural Route Number,
	s affer el Dire ed in by	Certification:	4 Homicide	building, etc	c. (Specify)			City or Tov	vn, State)	
Division of Vital Records, P.O. Box 687 To the Hospitel or Attending Physicien: The law requires that the death certificate	within 24 hours after dearn. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2		(Check only 2 Medical Examin	er: On the basis of	examination and/or	ath occurred at the ti	me, date and place, opinion, death occur	and due to the ed at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
the i	To the Complet	Medical	29b. Signature and title of certifier	and manner sta	ited.	29c. Licens	se number		29d. Date signed (Mor	th, Day, Year)
Ĕ	¥ ⊬ 8		1 1	ui Mo		Done	59987		1/8/06	
7			30. Name and address of per of who cor		eath (Item 23a) (Typ				1,100	
	u		C. Vacinoni		Seton F	Jr. Ou	mb. Me	2150	7	
148	∘ St	ate	31. Date filed (Month Pay, Year)	JZ. Hegistr	ar's Signature					

State Registrar

31. Date filed (Month, Pay, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year ANNA MARIE KOONTZ **JANUARY 7, 2006** 11:30 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ST. CATHERINE'S NURSING CENTER FREDERICK EMMITSBURG 8. Date of Birth (Month, Day, Year) JULY 26,1929 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days Hours Months 1 M 2 XF Yrs. EMMITSBURG, MD. Director 76 212-30-3299 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. If Importent: If Item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other treumatic event, If we Medical Examiner must be notified at once. 10c. City. Town or Location 10a State 10b County 10d. Inside City Limits 1 ☐ Yes 2 X No Director EMMITSBURG MD FREDERICK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17348A N. SETON AVE. 21727 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by Specify: WHTTE 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OFFICE WORKER FEDERAL GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BERNARD HUGH BOYLE MARY Ε. BOLLINGER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT LEE KOONTZ, JR./SON 14928 KELABAUGH RD., THURMONT, MD. 21788 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1/12/2006 EMMITSBURG MEMORIAL ^ 4 □ Donation 5 □ Other (Specify) EMMITSBURG, MD. 21727 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, MD. 21/2/ Pw 1/ Enter the disease, or complications that caused the death. s look, or heart failure. List only one caus, on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Peath Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed as the burial-transit au Mo resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 \(\sum \) Yes \(2 \sum \) No Dav 4 Pregnant at time of death 5 Other (specify) the à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 Yes 2X No 1 Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 2 1 ☐ Yes 2X No 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: fter 5 Pending Injury 1 X Natural death 1 ☐ Yes 2 ☐ No investigation after death Director: 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide urs Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magnes stated. (Check only one) To the within 2 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) JANUARY 9, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5

DHMH 17 Rev 1/200

State

Registrar

ALAN CARROLL, M.D.

JAN 1 2 2006

31. Date filed (Month, Day, Year)

EMMITSBURG, MD. 21727

310 S. SETON AVE.,

2. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year 03:45 M WILLIAM LAMB JANUARY 03 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE CITY HOPKINS HOSPITAL THE JOHNS If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2□F Months Hours Yrs Director May 13, 164-26-5549 New Jersey Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 Is marked othar than "natural", or items 23a or 28a-f show traumatic avent, the Medical Examinar must be ricitified at 1 ☐ Yes 2 🙀 No Directo Ceci1 Maryland Earleville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 49 Hacks Point Road 21919 United States Completed by Funeral 12. Was Decedent Ever in U.S.
Armed Forces? Korean
1 ™ Yes, 2 □ No
If Yes, Give
Year or Dates: War Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within: h and Mental Hygiene. 7 Is marked othar than "r Elementary/Secondary (0-12) College (1-4or 5+) Millwright Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William E. Lamb, Sr. Marion Rossell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itam 27 I Gisela Lamb/Wife 49 Hacks Point Road, Earleville, Maryland 21919 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State West Chester, Date permit. Pages 1 Department of H Important: If its any injury or ot once. January 4, 2006 4 □ Donation 5 □ Other (Specify) R.A. Ferris & Co. Inc. Pennsylvania Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 21. Signature of Funeral Service Licenses Risman rester luch 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PULMONARY EMBOLISM Physician hours disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 3 Months ADENOCARCINOMA OF THE LUNG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine certificate be executed use as the burial-tran and resulting in death) Last Due to (or as a consequence of) 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1∐ Yes 2 No 1 TYes Hospital or Attanding Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 X No Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1. Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funaral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 2 ths 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 PETER LEARY, MEDICAL DOCTOR RES-000 JANUARY 3, ZOOG 6+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PETER CEARY, THE JOHNS HOPKINS HOSPITAL, 600 N. WOLFE STREET BALTIMORE MARYLAND 21231 22. Registrar's Signature 0 2006 State Registrar

AEM 06-00079 Timothy M. Mil	Please Type or Print Unpend iten#23a,27,28a-f,penME,G ler_ State of Man	in Black Indelible Ink. Ensure All Copie 853,3/2/00 II yland / Department of Health and Mental H	s Are Legible.
	1 - For Registrar	Certificate of Death	Reg. No.
Physician	Decedent's Name (First, Middle, Last)	2. Date of I Month	Death 3. Time of Death
/Medical	Timothy M. Miller 4a. Facility Name (If not institution, give street and number)	Janau	ry 3, 2006 1:50 P M
Examiner	2000 Rockland Avenue	4b. City, Town, or Location of Death Rockville	4c. County of Death
Funeral Director		In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of E Months Days Hours Min. (Month, I	Montgomery Sirth Day, Year) 9. Birthplace (State or Foreign Country) 8,1956 MD
Maryland follow model		Oc. City, Town or Location Rockville	10d. Inside City Limits 1 \(\overline{\chi} \) Yes 2 \(\overline{\chi} \) No
Suffer death with the Marklers 23a or 28a-1 endiffed	10e. Street and Number 2000 Rockland Avenue	10f. Zip Code 20851	10g. Citizen of What Country? United States
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Dependment of Heath and Mental Hygiene. Important: If time 72 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Madical Exeminant be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Eve Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	er in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 1 Yes 2 No Specify:	No- 14. Race - American Indian, Black, White, etc. Specify: White
121215-00 yeld within 72 hou yelden. The wallest in the wallest Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)		16b. Kind of Business/Industry
121 lied w Hygien nt, in the	12 17. Father's Name (First, Middle, Last)	Salesman	Furniture
yland yland build be fil mental H mrked out	Norman Miller	18. Mother's Name (First, Midd Shirley Pumph	
ary shou and M mar	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Num	
end 2 end 2 lealth m 27 i	Merle B. Miller / Wife	14000 Cove Lane #203, Rockvi	
Baltimore, Maryland 21215-0036 Sermit. Pages I and 2 should be filed within 72 hours att Deperment of Health and Marial Hygiens. In proteint: If item 27 is marked other than "natural", or my injury or other traumatic event, the Marical Exerci- Dice. To Be Completed by F	20a. Method of Disposition 1 🛣 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Rockville Union Date January 6	20c. Location - City or Town, State Rockville, MD
Balt permit Depert Import	21. Signature of Funeral Service Licensee RACY A Stuven	22. Name and Address of Facility DeVol Fu Deer Park Drive, Gaithers	neral Home, 10 East burg, MD 20877
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) List only one cause on each line. Back injury Due to (or as a c	with complications consequence of):	arrest, Approximate Interval Between Onset and Death
8760, rate be executed hysicien and the burial-transit	Sequentially list conditions, 1 any, leading to intracdiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Cus to (or as a condition of the condition of the cause). Cus to condition of the cause (or as a condition of the cause).		
Division of Vital Records, P.O. Box 68760, for Attending Physician: The law requires that the death certificate be executed action and biractor. After this certificate has been signed by the ettending physicien and in by the funeral director, page 2 should be detached for use as the burial-trief in by the Completed by Physiclan/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of 1 □ Live birth 2 □ 4 □ Pregnant at time 1 □ Unknown	Fetal death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
Cords, P	Part II. Other significant conditions contributing to death but r		d tobacco use contribute to the cause of death? ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
Recorr The law requeste has been page 2 should		per	as an loss of the completion of cause of death? 2 □ No 1 SV es 2 □ No
Vital Fidelen: The certificate rector, pag	25. Was case referred to medical	26. Place of Death Check only	
Of \Physic Physic ral direction of To	1 → Yes 2 No Hospital: 1 Inpatient		sidence 6 Sether (Specify) Scene
Division (teal or Attending P as eleft death in Director Affer led in by the funera Certification;	1 Natural 5 Pending (Month, Day Y. 2 Accident investigation Dec. 28, 200	06 unk M 1□Yes XX Deceased	Fell
Div pital or A urs effer rral Directilled in by	4 Homicide determined building, etc. ((Specify) City or T Rockvill	
Division of Vital Rewither Hospital or Attending Physician: The within 24 hours effer death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification; To Be Com	29a. Certifier (Check only one) April 1 Certifying Physician: To the best of more and mapping state.	V I A	e, date and place, and due to the cause(s)
or wild or or or or or or or or or or or or or	29b. Signature and title of contribet	29c. License number OCME	January 4, 2006
	30. Name and address of person who completed ca of deat	th (Nem 23a) (Type, Print) More, Maryland 21201 S.R. H.C	
State	31. Date filed (Month, Day, Year) 32. Registrar's	s Signature Figure 1 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2	0/// 0,10(1)

CPM 06-00010 Artie Marine

/Medical

Examiner

Funeral

Director

rel', or iteme 23a or 28a-f ehow Examiner must be notified at

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item 27 i

Department of Himportant: If its eny injury or of page.

Director

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Completed

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with

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

Amend Unpend item#1,2a,27,2a-f,pen#1,052,2/6/06 IT
State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend item#1, perME, C852, 2/7/06 TT Certificate of Death 00653 Reg. No: 1. Decedent's Name (First, Middle, Last) Artic Marine Artic Marine, Sr. 2. Date of Death 3. Time of Death January OI, Artie Sherwood Marine Sr. 2**0**06 05:28 A M 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Dorchester General Hospital Cambridge
If Under 1 Year | If Under 24 Hrs. Dorchester 8. Date of Birth (Month, Day, Year) 03/12/1965 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) Months Days Hours 1⊠M 2□F 40 Yrs. 218-82-0197 Maryland Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a State 10h Counts 1X Yes 2 No MD Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 504 Glenburne Ave. 21613 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 M Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: Black 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Transportation/Driver **DDUST** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Marine SR. Doris Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Easton, MD 21601 Tasha Jenkins/ Daughter 109 Hammond St. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 DBurial 2 Cremation 3 Removal from State Veterans Cemetary 01-09-06 Hurlock, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Foneral Service Licensee 22. Name and Address of Facility 426 Dover ST Bennie Smith Funeral Home-Easton, MD 21601 23a. Part1. An other disense, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on eart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cocaine Intoxication Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

Examine nding physicien and use as the burial-transit Physician/Medical ģ Completed certificete Be ို After thi Certification: Diractor:

Hospital or Attending Physician: The law requires that the death certificate be executed

death.

within 24 hours after d

To the Funaral Diract
completely filled in by

the state of

Medical

Division of Vital Records, P.O. Box 68760.

24a. Was an

autopsy performed? Yes 2□ No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1△ Yes 2□ No

25. Was case referred to medical 17 Yes 2□ No 27. Manner of Death

1 Natural

2 Accident

4 Homicide

3 ☐ Suicide

29a, Certifier

spital: 1 □ Inpatient 2 N 28a. Date of Injury (Month, Day Year) 5 ☐ Pending investigation

2 X ER/Outpatient 3□ DOA 28b. Time of Find Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1/1/06 1 ☐ Yes 2 **X** No **unk** 4:45 A

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Found in vehicle

28f. Location (Street and Number of Rural Route Number, City or Town, State) 1222 Hudson Road Cambridge MD

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

_JAN 0 3 2006

29c. License number

29d. Date signed (Month, Day, Year)

O.C.M.E.

January 02, 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AWA KUBIO, MO 31. Date filed (Month, Day, Year)

6 Could not be

determined

111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Yea Albert Cloyd Owens JANUARY 2006 /Medical 19:36 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL CUMBERLAND ALLEGANY 8. Date of Birth Month, Day, Y Aug 29, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral** Months 1(XM 2□ F 217-18-4202 82 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at MD Allegany Cumberland 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 12705 Bedford Road, NE 21502 USA Funeral items. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. fited within 72 hours after 1 Never Married 2 Married 1 X Yes 2 ∏ No If Yes, Give Year or Dates: 5 Baltimore, Maryland 21215-0036 1 Yes 2 No δ WW II Specify: white 3 Widowed 4 Divorced "natural" Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be fitted within 7. Department of Health and Mental Hyglene. Important: If item 27 is marked other then "ne eny injury or other traumatic event, "te Media once. Elementary/Secondary (0-12) College (1-4or 5+) Machinist Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Clarence Owens Margaret Owens a. Informant's Name/Relationship *(Type, Print)* Norma Owens 19b. Mailing Address (Street and Number or Ryral Route Number, City or Town, State, Zip Code) 12705 Bedford Road NE Cumberland MD 21502 wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Hillcrest Memorial Park 1/7/2006 Cumberland MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Sen ^{22. Nam}Scanden fune yal Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Enter the disease, or complication or heart failure. List only one or complication the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HEMORRHAGE INTRACEREBRAL RIGHT /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Dus to (or as a consequence of). Examiner sete hes been signed by the ettending physiclen and page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Be Completed 1 Yes 2 No 3 Probably 4 🗀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 2 No 1 Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No Certification: To 1 inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation death. 1 Yes 2 No Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide To the Hospitel within 24 hours at To the Funeral D filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D14389 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AUGUSTO FIGUEROA. 625 KENT AVE., SUITE 306, CUMBERLAND, MD 21502 31. Date filed (Month, Day, Year) State JAN 1 3 2006 Registrar

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

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Mary land

2:10 p M

2006

Records, Vital of Division Hospital or Attending

20c. Location - City or Town, State Woodsboro, MD Skiles Funeral Home 136 E. Baltimore St., Taneytown, MD 21787 Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy ostedar 1 ☐ Yes 2 **X**No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ٩ 1 ☐ Yes 2 2 No 1 [] Inpatient 2 ER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date/signed (Month, Day, Year) (oral 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Curley, M.D. Christine A. 302 W. Main St., Emmitsburg, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature 13 2006

To the Hospinson within 24 hours efter d

death.

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To the Fund completely f

State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year 10:30 PM Richard Campbell Peiffer January 4, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 13633 Little Antietam Rd. Hagerstown Washington 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year 1918 Birthplace (State or Foreign Country) Days 1 1 2M 2 1 F Director 87 Yrs. 217-10-3174 30, Pennsylvania October Usual Residence of Decedent the Maryland 10a State 10h County 10c. City. Town or Location 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Exandrer must be notified at 10d. Inside City Limits Directo 1 ☐ Yes 2 X No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13633 Little Antietam Road 21742 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 1941 — If Yes, Give Year or Dates: 1945 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 À 1 ☐ Yes 2 No Specify Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "r any injury or other traumatic event, the Mext gongs. Elementary/Secondary (0-12) College (1-4or 5+) 12 Assembly Line Machine Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ruth McKelvey J. Wallace Peiffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) *Nellie Marie Peiffer* (Wife) 13633 Little Antietam Rd. Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State St. Paul's Lutheran 1

Burial 2 □ Cremation 3 □ Removal from State January * 4 ☐ Donation 5 ☐ Other (Specify) 2006 Leitersburg, Maryland Church Cemeteru 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Maryland 21783 M01414 DAVIS 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CARPIAL disease or condition resulting in death) MMITTER /Medical Due to (or as a consequence of) **Examiner** 1005 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): 68760 physician Physiclan/Medical the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) Records, P.O. the 9☐ Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed certificete Vital 1 Yes No No the Hospital or Attending Physiclen: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 🗌 Inpatient o 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division 1 Natural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 - Homicide 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2006 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) a steven 2 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			For	artment of Health and Me	Reg. N	IIIh UUbjo
	Physici /Medic Examin	al	Decedent's Name (First, Middle, Last) NELLIE VIRGINIA PIPPIN 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	JANUARY	4 2006 2:50a M
	Funeral Director		164 North Main St. 5. Social Security Number 218-20-8069 Usual Residence of Decedent 1 Main St. 6. Sex 1 Main St. 7. Age (In yrs. last birthday,		Date of Birth (Month, Day, Yea Ceb 10 1	9. Birthplace (State or Foreign 921 Maryland
	the Maryland 28e-f show	rector	10a. State	ocation 10f. Zip Code	10g. (10d. Inside City Limits 1'' Yes 2 □ No Citizen of What Country?
36	be filed within 72 hours after death with the Maryland tal Hyglene d other than "natural", or Items 23a or 28e-f show event, the Medical Exapirer must be notified at	by Funeral Director	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No	21635 Was Decedent of Hispanic Origin? (Specifi Yes, specify Cuban, Mexican, Puerto Ri	ify Yes or No-	J.S.A. 14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	d within 72 hours piene. r than "natural"	Completed b	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2. 1 Specify only highest grade completed (Give life.) College (1-4or 5+) Vic	edent's Usual Occupation a kind of work done during most of working DO NOT use retired) Ce President		Kind of Business/Industry
Maryland 2	should be filed v nd Mental Hygie t marked other t umatic event, ID	To Be C	Charles A. Miller, Jr.	18. Mother's Name (in Leaner M. Leaner M. Leaner M. Leaner M. Leaner M. Leaner or Rural R. Leaner or R. Leaner or Rural R. Leaner or R. Lean	agalean	e Atkinson
Baltimore, Ma	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ex QDCe.		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) 20b. Place of Disposition State Calena	80 East Point Rd contion (Name of place) Cemetery 1/8/	te 20c.	ock, VA. 23417 Location City or Town, State lena, MD.
Balt	permit. Depart Import any inj		G G	18 West Cross St	. Galen	tephen L. Schaeck La, MD. 21635 Approximate Interval Between Onset and Death
8760,	death certificate be executed Wagnetical e attending physician and for use as the burial-transit	lical Examiner	resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	Mcev		
.O. Box 6	at the death certifica by the attending pt tached for use as ti	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 1 10 0 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 4 □ Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
Records, P.	The law requires that tate has been signed by page 2 should be detail	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	1 🗆 Yes	o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
Vital Rec		Be Completed	25. Was case referred to medical	26. Place of Death (24a. Was an autopsy performed? 1 Yes 2 X	
Division of V	or Attending Physics death. irector: After this a by the funeral director.	Certification: To	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	of 28c. Injury at 28 Work? M 1 ☐ Yes 2 ☐ No	3d. Describe how in	and Number or Rural Route Number,
	the Hospite in 24 hours the Funeral poletely filled	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deal of the basis of examination and/or in and manner stated.		at the time, date a	
	To To Con	-	29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type	D39887	230.	21620
	Sta Regist	ate rar		nurch Hill Rd. St	uite 100	Chestertown MD.

CPM 06-00132 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item 2a, 27, per 1,052,2/9/0 II
State of Maryland / Department of Health and Mental Hygiene Dennis Purcell 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Dennis James Purcell January 05, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 2158 Marbella Drive Waldorf Charles | Months | Days | Hours | Min. | March | 19, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□F Yrs Director 219-58-9529 53 1952 Washington DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r then "neturel", or iteme 23a or 28a-f eho the Medical Examiner must be notified at 1 ☐ Yes 🗶 No Directo Maryland Charles Waldorf the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ↑ 23a c 2158 Marbella Drive 20601 USA death Funeral lteme. 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "neturel", or 1 ☐ Yes 2 No Specify: White þ Specify: 3 ☐ Widowed 4 🂢 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 end 2 should be filed within Deperment of Health and Mental Hyglene. Important: if item 27 ie marked other then "n eny injury or other treumatic event, Ita Mad 2008. Elementary/Secondary (0-12) College (1-4or 5+) Sheriff Law Enforcement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Walter Joseph Purcell Louise Elizabeth Wolf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Purcell - Son 15700 Main Blvd., Accokeek, MD 20607 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Huntt Crematory 4 ☐ Donation 5 ☐ Other (Specify) 1-6-06 Waldorf, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M01391 3035 Old Washington Road Total Agol Huntt Funeral Home Waldorf, MD 20601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Seizure Disorder /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Example of injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ettending physicien end for use es the burial-transit or Attending Physicien: The law requires thet the death certificate be executed Due to (or as a consequence of). Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) detached Division of Vital Records, P.O. 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ icete hes been sig 3 ☐ Probably 4 ☐ Doknown Completed 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ ∀es 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence MOther (Specify) SCENE 2 1 XYes 2 No 3 DOA Pis 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending efter death.

Director: Af
d in by the fu 1 Yes 2 No 2 Accident investigation M 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 06, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANA MD 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year)

AN 0 9 2006 32. Raistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

		1 - For State Registrar	State o	f Maryland		artment of H tificate of I		nd Mental	Hygiene Reg. No	UUU	00660
Physic	ian	Decedent's Name (First, Middle	-,,				-	Mont		y Year	3. Time of Death
/Med Exami		4a. Facility Name (If not institution	evieve Del n, give street and nur		een	4b. City, Town, or	Location of [, 2006 County of Dea	
- 1	gar j	St. Mary's Hos	spital			Leonard			S	t. Mary	's
Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 X F	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hours	Min. (Mont	h, Day, Year,	0	thplace (State or Foreign ountry)
Director		214-36-2676 Usual Residence of Decedent		6	9 Yrs.			April	16, 193	66 Mar	yland
yland how		10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
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or 28	Dire	10e. Street and Number				10f. Zip Code			10g. Ci	tizen of What C	ountry?
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ter de	Funerai	11. Marital Status 1 X Never Married 2 ☐ Marr	Armed Fo	rces?	1	Was Decedent of Hi f Yes, specify Cuba	n, Mexican, F	uerto Rican, et	or No- c.)	14. Race - Am Black, Whi	
DOULES A	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes Giv	/8		I□Yes 2Ã No	Specify:			Specify: B	lack
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at y ide III of I of I of I of I of I of I of I	To Be	Joseph Melton 1	Butler				Agnes	Belton	Oueen	,	
s mar	-	19a. Informant's Name/Relations			19b. Mailin	g Address (Street a				or Town, State,	Zip Code)
and 2 and 2 aalth n 27 i		Brenda Delores Que	en / Daught			Hollywood R	oad, Led	onardtown	, Maryla	ind 20650	
D Ses 1		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 Removal from	State Char	nce of Dispo	sition <i>(Name of</i> natory or other plac orial	e)	Date January	20c. L	ocation - City or	Town, State
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked other then "netural", or Items 23s or 28a-f ehow piny or other traumatic event, it a Medical Examinant or nothing at once.		4 Donation 5 Other (S		Onar	Garde	ns		7, 2006	Leon	ardtown,	Maryland
Department of the partment of		21. Signature of Funeral Service	Licensee	disasi	Mat	Name and Address	rdiner I				
		23a. Part1. Enter the disease, or	complications that c	aused the death.			•			en City or Town, State, Zip Code) raland 20650 ic. Location - City or Town, State eonardtown, Maryland 2.A. d 20650	
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ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	Due to (or as a conseque	ence of):						
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ath cert	lan/	23b. Was decedent pregnant in the past 12 months?	1 Live b	come of pregnan inth 2 - Fetal o	death 3□	Ectopic pregnancy					,
w requires that the death certific been signed by the attending f should be detached for use as	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4∐Pregn 9☐ Unkno	ant at time of dea	ath 5∟	Other (specify)					Juy Tour
that the detail		Part II. Other significant condition	ons contributing to di	eath but not resul	ting in the ur	nderlying cause give	en in Part I.	23e.	Did tobacco	use contribute t	o the cause of death?
w requires t been signe should be	ed by							_	1 ☐ Yes 2	□ No 3 □ P	robably 4/1Unknown
aw re	plet							24a.	Was an	24b. Were a	utopsy findings available completion of cause of
VICAL DEC sician: The law s certificate has b lirector, page 2 s	Completed							10	autopsy performed? res 22 No	death?	completion of cause of
cian:	Be (25. Was case referred to medica examiner?						Death (Check	only one)		
Physical direction	2	1 ✓ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 🗆 I		Routpatien 28b. Time of		4 Nursi			6 ☐Other (Spe	ecify)
ding Physith. After this funeral di	tjon	1 Natural 5 Pendin	ng (Mont	th, Day Year)	Injury	Worl	γαι ⟨? Yes 2∐No		ribe how inju	iry occurred	
Attending r death. •ctor: Afte by the fune	ifica	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place	of Injury - At hor	ne, farm, str	eet, factory, office		28f. Local	ion (Street a	nd Number or R	ural Route Number,
tel or is after all Dir	Certification:	4 Homiciae	Duildi	ng, etc. (Specify)				City	or Town, Stat	θ)	
To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier 1 Certifyir (Check only one) 1 Medical	ng Physician: To the Examiner: On the band man	best of my know asis of examinationer stated.	rledge, death on and/or in	occurred at the time vestigation, in my of	ne, date and pointion, death	olace, and due to occurred at the	the cause(s	and manner a d place, and du	s stated. e to the cause(s)
To the within To the comp	×	29b. Signature and title of certifie	r			29c. License	e number		29d. Da	ate signed (Mon	th, Day, Year)
\wedge		Im m	20			000	6283	39	Jan	mary /	2006
l)		30. Name and address of person	who completed caus	se of death (Item	23a) (Type,	Print) S HOSPITA	. 1 1 -	100-11		no In	nd
3 9	ate	31. Date filed (Month, Day, Year)	32. F	カーナク gistrar's Signati	110	s HOSPIA	ex Lea	nura to	WN /	yary ru	
Regist		JAN 0	4 2006	ection a	H A	need a					

		1 = For State Registrar	State of Marylar		tment of H			ene (6 000	561
Physi /Med	dical	1. Decedent's Name (First, Middle, Las Elizabeth 4a. Facility Name (If not institution, give	M. Rhoo		th Ch Taur		2. Date of Death Month	10 2	2006 17	me of Death
Funera	æ . al'	Franklin Sylls 5. Social Security Number 6. So	are Hospi	fall last birthday)	Rose If Under 1 Year Months Days	Location of Death A P If Under 24 Hrs. Hours Min.		4c. Count		
Directo		Usual Residence of Decedent 10a. State 10b. County MD n/a	01	ity, Town or Loca	tion		iviay 25,	1324	10d. Insi	de City Limits
with the Ma a or 28a-f	Directo	10e. Street and Number 1 Eastern Bouleval	rd	Daitime	10f. Zip Code	21221	10	g. Citizen of	What Country?	Yes 2□No
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Exempler invest be notified at	Completed by Funeral Director	11. Marital Status The Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in L Armed Forces? 1 ☐ Yes 2€ No If Yes, Give Year or Dates:	10	as Decedent of Hi res, specify Cuba	ispanic Origin? (S n, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)	14. Ra Bla Specii	ce - American India ick, White, etc.	ın,
Maryland 21215-0036 nd 2 should be filed within 72 hours aff tilth and Mental Hygiene. 27 Is marked other then "naturel", or r traumatic event, the Medical Exert	complete	15. Decedent's Ed (Specify only highest gra-		homema		ation during most of wor))	rking	wn hon	ne	
aryland should be file and Mental Hyge marked other umatic event,	To Be C	17. Father's Name (First, Middle, Last) Harley Ray Rhoo					ne (First, Middle, M lanch (Ba			
and 2 sho ealth and n 27 is m		19a. Informant's Name/Relationship (7 Mary Ann Antos	sister	7510°	Address (Street a Belmont	Avenue	Baltimo	City or Town IC	, State Zic Code) MD 21	224
Baltimore, Dermit Pages 1 are Department of Hea mportant: If Item		20a. Method of Disposition 1 🖰 Burial 2 🗆 Cremation 3 🗆 4 🗆 Donation 5 🗆 Other (Specify	Removal from State Abe	Place of Disposit cemetery, crema e Cemetery	tory or other place	9)		Oc. Location Short C	- City or Town, Sta Sap	WV
Baltimo		21. Signatury of Funeral Service Licen	11/11/1		108 Virgi		e: Cumberla		21502	
figure be executed Wedica Examine Dhysician and st the burial-transit	dicai Examiner	23a. Pari 1, Ever the disease, or comphod, or heart failure. List inly disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect to the conse	quence of):	the mode of dying	g, such as cardiac	or respiratory arre	st,		kimate il Between and Death
.O. Box the death cert y the attending ched for use in	Physician/Med	iF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of of 9 ☐ Unknown	at death 3 E	ctopic pregnancy other (specify)				ite of delivery onth Day	Year
cords, P. w requires that been signed b. should be deta	þ	Part II. Other significant conditions co	entributing to death but not res	\circ	erlying cause give	on in Part I.		acco use con	tribute to the cause	e of death?
Division of Vital Records, for Attending Physician: The law requires to after death. Director: Atten this certificate has been signe in by the tuneral director, page 2 should be e	e Completed	25. Was case referred to medical						ed?	Were autopsy find prior to completion death? 1 ☐ Yes 2 ☐ No	of cause of
Vill s cert directe	0 0	examiner?	Hospital: Inpatient 2] ER/Outpatient	3□ DOA Othe	-	th <i>Check only one</i> ome 5 ☐ Resider		(0()	
Vision of Vita Attending Physician: r death. •ctor: After this certifice by the funeral director, it	-	27. Manner of Death Natural 5 Pending Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe how			
Division of Vital Re- To the Hospital or Attending Physician: The la- within 24 hours effer death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification;	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Speci	(y)			City or Town,	State)	per or Rural Route	Number,
Div To the Hospital or within 24 hours afte To the Funeral Dir completely filled in I	ledicai	one) 2 Medical Examples	vsician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death o ation and/or inves	stigation, in my op	oinion, death occu	, and due to the cau rred at the time, dat	use(s) and ma e and place,	anner as stated. and due to the cau	ise(s)
7 × 10 × 10 × 10 × 10 × 10 × 10 × 10 × 1	Σ	29b. Signature and title of certifier			29c. License				d (Month, Day, Ye	
· }		30. Name and address of person who g	ompleted cause of death (Itel		nt)	Drive	Baltin	•	0 - 200	
S Regis	tate trar	31. Date filed (Month, Day, Year)	32. Registrar's Signa	atus de la constante de la con	VILL TE	7/10	1 Dellin	1018 1	111,01	-51

DHMH 17 Rev 1/2001

Elizabeth

Rhode

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Clarice L. Rosenfield Jan 2006 9:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner William Hill Manor Easton Talbot If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 🗓 F Yrs. Director 006-20-7139 Auburn Maine Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examination ust be inclined at 1 XYes 2 ☐ No Director Talbot Easton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 633 Howard Street 21601 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ☐Yes 2 No 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event." Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Ernest Hyman Sarah Krepshan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) <u> Aaron Rosenfield / Spouse</u> 633 Howard Street, Easton, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Oxford Cemetery 1/3/2006 Oxford, MD 22. Name and Address of Facility Fellows, Helfenbein and Newnam Funeral Home PA 21. Signature of Funeral Service Licensee 200 S. Harrison Street, Easton, MD 21601 JOHN R. MERCERON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical attending f IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ discase 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Steoporosi's 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2XNo Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Sursing Home 5 Residence 6 Other (Specify) 2 28a. Date of Injury (Month, Day Year) Magner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours e To the Funeral [1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number D 35284 29b. Signature and the of perting 29d. Date signed (Month, Day, Year) 1/2/06

State Registrar DHMH 17 Rev 1/2001

Aclow mo

npleted cause of death (Item 23a) (Type, Print) who 219 S. (July

32. Registrar's Signature

Washington 8+ Eastmmn 2601

			1 - For State Registrar	State	of Maryla		artment of H tificate of		ind Me		giene ()	6 (0663
	Physicia	an	1. Decedent's Name (First, Middl						2	2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic		John	Giffin		Ridgeway				January		06	2:12 P M
	Examin	er	4a. Facility Name (If not institution	. •	umber)		4b. City, Town, o		f Death		4c. County		
		3	Memorial Hosp 5. Social Security Number	6. Sex	7 Age (In v	rs. last birthday)	Cumbe:		24 Hrs. s	8. Date of Birth		egany	and (State or Femilia
	Funeral Director		214-05-6119	№ M 2□ F	92	Yrs.	Months Days	Hours		Nov 17	1912	Coun	ece (State or Foreign
	ם .		Usual Residence of Decedent								,		
	arylar show	_	NV Was		10c.	City, Town or Lo Crysta						10	od. Inside City Limits
	Ne M.	Director				Orysia							Yes 2□No
	hours after death with the Maryland turel; or Items 23s or 28s-f show at Exemirer must be notified at		P.O. Box 685				10f. Zip Code	39402			10g. Citizen of		iry?
	Jeath	Funeral	11. Marital Status	12. Was De	cedent Ever in	U.S. 13.1	Was Decedent of H		zin? (Spec	ifv Yes or No-		ce - America	an Indian.
٥	after o	五	1 Never Married 2 Mar	ied Armed I	2 🗆 No		fYes, specify Cuba 1 □ Yes 2 No		, Puerto Ri	ican, etc.)	1	ck, White, e	etč.
53	ours a	d by	¾ Widowed 4 □ Divorced	Year or	Dates: WW	' 11	1 Yes 2No	Specify:			Specif	white	
<u>.</u>	be filed within 72 hours after death with the Marylan Hygiene. A Hygiene. do ther than "natural", or liems 23a or 28a-f show avent, tre Madical Examiner must be notified at	Completed	15. Deceder (Specify only highe	t's Education st grade completed	d)	(Give	dent's Usual Occup kind of work done	during most	of working	g	16b. Kind of B	lusiness/Ind	ustry
7	be filed within 72 Ital Hygiene. Id other than "nalesent, Ir e Madic	duc	Elementary/Secondary (0-12)	College	(1-4or 5+)		Com. Eng	,			J.S. Go	vernm	ent
2	filled Hygi other ent, I	Be Co	17. Father's Name (First, Middle,	Last)		Nadio	Join. Ling		r's Name (Maiden Surnai		CIIL
<u>lan</u>	should be filed word Mental Hygier marked other timatic svent, ID.	To B	George W. R	idgeway				Rose	eanna	a (Wrig	ght) Rid	geway	, '
Maryland 21215-0036	and and sum	5	19a. Informant's Name/Relations				ng Address (Street		r or Rural		r, City or Town		
		1	Jane Watson	tr	ust		Box 4090)8		Reno		NV	89504
Baltimore,	permit, Pages 1 and Department of Health Important; If item 27 any injury or other to once.		20a. Method of Disposition 1 Burial 2 □ Cremation	3 □Removal from	n State		natory or other plac	ce)	Da		20c. Location		
<u>ב</u>	t. Pag tmen tant;		`4 □Donation 5 □Other (S	pecify)	Ea	st View C		- 1		5/2006	Cumbe	erland	MD
Ba	permit, Departr Importu any inju		21. Signature of Funeral Service	Licensee	111	1 22	Name and Address Scarpell	i Funera	al Hom	ne, PA			
		7 7	23a. Part . Enter the disease, or	complicate os that	caused the de	eath. Do not ent	108 Virg	inia Ave	enue: (Cumberl	and, MD	21502	Approximate
			Immediate Cause (Final	only one cause or	each line.			ig, 30011 u.3 c	oardiac or	respiratory arr	1031,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	piratic o (oras a cons	n Pneum	onia					-	36 hours
	Examiner				sis	equerice or).						10	16 hours
	7 -	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		o (or as a cons	equence of):							
	acuted ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с									
SO,	oe exe	Ä	resulting in death) cast	Due to	o (or as a cons	equence of):							
8760	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dlcal		d								-	
X S	leath certific attending p	Physician/Me	IF FEMALE:	23c. If yes, o	utcome of preg	gnancy					224 Da	ite of deliver	
Rox	death atter	clar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live	birth 2 Fignant at time o	etal death 3	Ectopic pregnancy Other (specify)	/					y Day Year
o.	at the de by the a tached	hys	9 Unknown	9□ Unk	nown								
a, J	w requires that been signed b should be deta	by P	Part II. Other significant conditi							23e. Did to	bacco use con	tribute to the	e cause of death?
ord	equir en si ould l	ted	Ischemic Card	liomyopat	hy, Mil	d Renal	Insuffic	ciency	7	1 🗆 Y	es 2 No	3 🗌 Proba	bly 4 □Unknown
Records,	law r las be	Completed		<u>.</u>						24a. Was a		Were autop	sy findings available indicate of
		Co								perfor	med?	death?	
Vital	Physician: Th this certificate al director, pag	Be	25. Was case referred to medica examiner?				Oth			Check only or			
ō	Phys r this ral dii	. To	1 ☐ Yes 2 🔼 No 27. Manner of Death			☐ ER/Outpatien 28b. Time of		4 🗆 Nui			ence 6 Oth)
o	nding th. : Afte fune	t lor	1 X Natural 5 ☐ Pendir 2 ☐ Accident investi		e of Injury onth, Day Year,	Injury	Wor	k? Yes 2∐N			ow injury coour	100	
Division of	Atter	Certification:	3 Suicide 6 Could 4 Homicide determ	ined 288. Pla	ce of Injury - Al	t home, farm, str	eet, factory, office	-	28	If. Location (S	treet and Numl	ber or Rural	Route Number,
	tal or s afte al Dir ed in	Cert	4 I Nomicide	Duli	lding, etc. <i>(Spe</i>	ecily)				City or Tow	n, State)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier 1 Certifyii (Check only one) 1 Medical	ng Physician: To t Examiner: On the and ma	he best of my k basis of exam anner stated.	knowledge, death ination and/or in	n occurred at the tir vestigation, in my o	ne, date and pinion, deat	d place, an th occurred	d due to the c d at the time, d	ause(s) and make and place,	anner as sta and due to	ited. the cause(s)
	To t withi To tl	N	29b. Signature and title of certific	r . ,	110		29c. Licens	e number		2	29d. Date signe	d (Month, E	Pay, Year)
			> Hmath	euu	MD		D4	6346			Januar	у З	, 2006
	5		30. Name and address of person			, , , , .			1	1	AD 015	0.2	
		4.	Dr. Huma Shak		on Heig Segistrar's Sig			g., Cu	ımber	rand, N	MD 215	02	
	Sta Registr		JAN 0		A CASA	Jr A	ade						

Please Type or Print in Black Indelible ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month GENEVIEVE VIRGINIA RAILEY 06 5:55 A /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ST. VINCENET DE PAUL NURSING CENTER **FROSTBURG** ALLEGANY 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F Director 6-14-30 215-26**-**6987 MARYLAND Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location ed other then "natural, or items 23a or 28e-1 show event, Its Medical Example 1 at 1 10d, Inside City Limits 1 ☐ Yes 2 No MARYLAND | GARRETT LONACONING Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 8985 AVILTON ROAD 21539 Funerai U.S. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: WHITE Specify: þ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) it of Health and Mental Hygiene. If Item 27 is marked other ther or other treumatic event, Item 12 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOSEPH DICKEL IDELLA GORDON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOYCE RACE DAUGHTER 44 LINDEN STREET FROSTBURG MD 21532 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: if any injury or once. ROCKY GAP VETERANS 1-6-06 4 Donation 5 ☐ Other (Specify) FLINTSTONE, MD 21530 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 60 W. MAIN STREET m Sowers SOWERS FUNERAL HOME, P.A. Mar moa547 FROSTBURG, MD 21532 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final CERVIX **Physician** MONTHS disease or condition resulting in death) ARCINOMA /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) physicien and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending pt IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate 1 Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No o 24 hours after death.

Funerei Director: A
letely filled in by the fu death. investigation 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide i Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) within 2 To the F complet 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Harjit S. Sidhu, M. D., 925 Bis

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Highm

925 Bishop Walsh Drive, Cumberland, MD 21502

D2690

JANUARY 03, 2006

			For State Registrar	State of Maryla			nt of Health <i>te of Deatl</i>			ene 0 6	00665
			Decedent's Name (First, Middle, Last,)				2	. Date of Death	1	3. Time of Death
	Physici	76	Donna Le	ee Russe	11				Month January	Day Year 3, 2006	1:32 p.m ^M
	/Medic Examin		4a. Facility Name (If not institution, give		-+	4b. Cit	, Town, or Location			4c. County of Dea	
	LAGIIII		St. Mary's Hosp	ital			Leonardt	own		St. Ma	ry's
	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs	s. last birthday)			er 24 Hrs. g	Date of Birth (Month, Day,	9. Bi	rthplace (State or Foreign ountry)
*	Director	. [215-52-7068	M 2₩F 57	Yrs.	Month	Days Hours	NIII.	ov. 4,	1948 Ma	ryland
	D	7	Usual Residence of Decedent								
	how		10a. State 10b. County	10c. C	City, Town or Lo	ocation					10d. Inside City Limits
	Ma	to	Maryland St. Ma	ry's	L	exin	gton Park				1 Yes 2 No
	h th	Director	10e. Street and Number			10f. Z	ip Code		10	g. Citizen of What C	ountry?
	th wil	<u>a</u>	21672 North Ess	ex Drive			20653			United S	tates
21215-0036	172 hours after death with the Maryland "natural", or Itema 23a or 28a-f show idical Extrallier count be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Vidowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 顧 No If Yes, Give Year or Dates:			edent of Hispanic C ecify Cuban, Mexic 28 No Specif		fy Yes or No- can, etc.)	14. Race - Am Black, Wh Specify: Wh	ite, etc.
Ö	turs	ed	15. Decedent's Edu	cation	16a. Dece	dent's Us	ual Occupation			16b. Kind of Busines:	s/Industry
5	in 72	Completed	(Specify only highest grad	e completed)	(Give	kind of v	vork done during mo use retired)	ost of working			,
12	d within giene. r than "	E	Elementary/Secondary (0-12)	College (1-4or 5+)	В	udge	t Analyst			U.S. Gove	rnment
9	Hyg the int,		17. Father's Name (First, Middle, Last)						First, Middle, M	Maiden Sumame)	
an	ould be Mental arked o	o Be	Emmitt Richard	Ruccoll				Tmose	ne Thon	กลต	
2	2 shoul and Me Is mark	F	19a. Informant's Name/Relationship (7)		19b. Maili	na Addre	ss (Street and Num			City or Town, State,	Zip Code)
Maryland	12 7 15 17		Imogene Russell		2167	2 NO	rth Fecer	Drive	Levir	ngton Park	, MD 20653
	s 1 and 2 f Health item 27		20a. Method of Disposition		Place of Dispo			DITVE	-	20c. Location - City o	
Baltimore,	S = S		1 Burial 2 ☐ Cremation 3 ☐ F	removal from State			+	1 (0	006	1.	36 221 1
Ë			4 Donation 5 Other (Specify)				rial Gdn.				n, Maryland
Bal	Departr Departr Importu any inju		21. Signature of Funeral Service Licens	15/2						Funeral H	
_	40240	-	Kyle S. Simo								D 20650-0279 Approximate
N. 44	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition	ne cause on each line.	Anoxi	c S	Brain	Ini.	s A	;ş.,	Interval Between Onset and Death
18	/Medical		resulting in death)	Due to (or as a conse				J			
	Examiner		O STATE OF THE STA	RESIDIR	tory 1	4rr	esT				-de-
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	equence of):			6			
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	Severe	Pinlm	enci	3 Fibr	2515			years
Ć	exec n an ial-tr	Exa	resulting in death) Last	Due to (or as a conse	equence of):						
68760,	ficate be executed physicien and s the buriat-transit	edical	(d							
89	ificat g phy as th		50-								
О. Вох	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3[⊒Ectopic ⊒ Other (pregnancy specify)			23d. Date of di Month	əlivery Day Year
Ω.	that t		Part II. Other significant conditions co	ntributing to death but not re	esulting in the u	underlying	cause given in Par	t I.	23e. Did tob	acco use contribute	to the cause of death?
Vital Records,	ires tha signed I d be det	1 by							1 ☐ Ye	s 2 No 3 7	Probably 4 Unknown
oro	w require been si should t	Completed									
ec	law last e2s	npl							24a. Was ar autops	v prior to	autopsy findings available completion of cause of
=	The Tate has page	Š							perform 1 Yes 2	ned? death?	s 2 No
ita	iician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?					ce of Death	Check only on	9)	
of \	hysio his co	2	1 Yes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3		Nursing Hom	e 5 🗆 Reside	nce 6 Other (Sp	ecify)
0	Attending Physician: If death. ector: After this certification is the funeral director.		27. Manner of Death 1 ■ Natural 5 ■ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	of	28c. Injury at Work?	28	3d. Describe ho	w injury occurred	
<u>ō</u>	ttending death. ctor: Aft	atic	2 Accident investigation			М	1 Tyes 2	□No			
Division	er de	iii	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec		reet, fact	ory, office	28	If. Location (St. City or Town	reet and Number or h	Rural Route Number,
Ö	s afte al Dire ed in t	Certification:		3, 5.5. (550							
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Exem	rsician: To the best of my kiner: On the basis of exami							
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stated.			9c. License numbe	or .	ار.	9d. Date Moned (Mon	oth Day Year)
	T VIII		2.55. Signature and title of Certifier	5			D2523		2.	9/4/	· · · · · · · · · · · · · · · · · · ·
			Dal (1	m 1933			10000			1/1/0	6
(0))		30. Name and address of person who							6	
W	/		David Allen, M.D			out	Road, Leo	nardto	wn, Mar	yland 206	50
1	Sta Regist		31. Date filed (Month, Day, Year)	2006 32. Rigistrar's Sig	nature	Joan	٧				

State of Maryland / Department of Health and Mental Hygiene 00666 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 221 4b. City, Town, or Location of Death 4c. County of Death am Rolfe George Α. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore Crty arylano reneral Baltimore If Under 1 Year 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Months Davs Hours Director 213-40-6062 April 15,1941 Maryland Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location d other then "neturel", or items 23e or 28e-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 27 No Director Maryland St. Mary's Hollywood 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 44661 Steer Horn Neck Rd. 20636 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1⊠Yes 2□No 1961— If Yes, Give Year or Dates: 1965 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: White ð 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Depertment of Health and Mental Hygiene, important: if item 27 is marked other then 'eny injury or other treumetic event, the Megone. Elementary/Secondary (0-12) College (1-4or 5+) Physical Security U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Harold Joseph Rolfe Laura Marie Moriarty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 44661 Steer Horn Neck Rd. Hollywood, MD. 20636 G. Shane Rolfe / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition W Burial 2 ☐ Cremation 3 ☐ Removal from State St. Michaels Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 1/7/2006 Ridge, Maryland 22. Name and Address of Facility Brinsfield Funeral Home PA. 21. Signature of Funeral Service Licenses Kyle S. Simons 22955 Hollywood Rd. Leonardtown, MD. M01206 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Cell Lung Cancer Physician/Medical Examiner The law requires that the death certificete be executed attending physician end for use es the buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown \$ Completed tate Cancer, Diabetes 24a. Was an autopsy performed? 24b. Were autopsy findings pege 2 should available prior to completion of cause of death? certificate has Mitus 1116 2 🖫 No 20 No 1 Tyes 1 Tes or Attending Physicien: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 No ၉ 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After 5 Pending investigation 1 Natural efter death. 1 Tyes 2 □ No 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours effer dec To the Funeral Director completely filled in by th 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) me and address of person who completed cause of death (Item 23a) (Type, Print) General n. D. 90 neyland uuka

Registrar

George Rolf

DHMH 16 Rev 6/95

State

31. Date filed (Month, Day, Year)

			1 - For State Registrar	State of Ma	aryland		artmen rtificat			and M		giene Reg. No.	006	0066	7
	Physicia		1. Decedent's Name (First, Middle, La	st)							2. Date of De Month	aath Day	Year	3. Time of De	eath
П,	/Medic		Marie 1	Tiorentino		Rezza	1				January		2006	6:20 p.	. m. ^M
	Examin		4a. Facility Name (If not institution, give	e street and number)			4b. City,	Town, or	Location o	of Death		4c.	County of Dea	th	
1			St. Mary's N	Nursing Cer	nter			Le	onard	town			St. Ma:	ry's	
	Funeral		5. Social Security Number 6. S		e (In yrs. la	st birthday)	If Under Months	1 Year Days	If Under:	24 Hrs. Min.	8. Date of Bit (Month, Da	rth	9. Bir	thplace (State or Fountry)	Foreign
	Director		153-16-48/5	□ M 2 F	86	Yrs.		54,0			12-2-1	919	Ita		
	po 🖈		Usual Residence of Decedent 10a. State 10b. County		10a Cibi	Town or Lo	tion							140.1 1 11 01	
	aryla eho	'n	Too. County		Too. City,	TOWIT OF ED	Cation							10d. Inside City	12.5
	88-f	octo	MD St. Ma	ry's	Me	chani		_						1 ☐ Yes 2	FE 140
	or 2	5	10e. Street and Number				10f. Zip					-	zen of What Co	,	
	ath v	Funeral Director	35840 Army Navy					20659					ted Sta		
	er de	nue	11. Marital Status	12. Was Decedent 8 Armed Forces?		. 13. \	Was Deced f Yes, spec	dent of Hi cify Cuba	spanic Orig n, Mexican	gin? (Spe 1, Pu <i>e</i> rto	ecify Yes or No Rican, etc.)	D-	 Race - Ame Black, White 		
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ∰Widowed 4 ☐ Divorced	1 ☐ Yes 2 ♣N	No		1 □ Yes	2 No	Specify:				Specify:	-	
21215-0036	hour ural	d b		Year or Dates:		10. 0						1		Mite	
फ़	"nat	Completed	15. Decedent's Ed (Specify only highest gra			16a. Deced		rk done d	luring most	t of work	ing	16b. Ki	nd of Business	/Industry	
12	within and the state of the sta	E D	Elementary/Secondary (0-12)	College (1-4or 5	+)				,			TT	S. Gove	wnm on t	
2 2	filed within 72 hours after death with the Maryland Hygiens. other then "natural", or Items 23s or 28e-f ehow ent, the Madical Exeminer must be notified at		12 17. Father's Name (First, Middle, Last,			00	okkee	per	18 Mothe	er's Name	e (First, Middle			riment	
aŭ	od o	Be c	Frank Fiorentino								ta Chri		,		
2	d Me mark matic	ဥ	19a. Informant's Name/Relationship (19b Mailir	an Address	(Street s					r Town, State,	Zio Codo)	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23s or 28e-f ehow eny injury or other treumatic event, the Medical Examiner must be notified at ones.		Robert Rezza/Son	**							nard, M	-		zip Code)	
	1 an Heal em 2		20a. Method of Disposition		20b. Pla	ice of Dispo					Date		cation - City or	Town State	
Baltimore,	it of or o		1 Burial 2 Cremation 3 □		cer	metery, cren	natory or o	ther plac	· 1						
Ë	t. Peritant		4 Donation 5 Other (Specif		MD \	/etera								Marylan	
Bal	Depermine Deperm		21. Signature of Funeral Service Lice	500										Iome, P.A	i •
_	40200		county on	1 11000	152								town, M	D 20650	
	Pnysician ₁		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each lin	ine death.	Do not ent	er the mod	or dyine	g, such as	cardiac d	or respiratory a	irrest,		Approximate Interval Betwe Onset and Lea	
	/Medical		disease or condition resulting in death)	a	a conseque	ence of):	way	10	um	102	- 1			nig	-
Id.	Examiner			1	0	Mast	120	- He	Van A	1-1-	rilur	e	-	WR	
		e	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	noe of):	VZ	JIE	KC//	1	·			0	111
	uted d ansit	Examine	Cause (Disease or injury that initiated events	. (ass	مرارا	mu.	so.	olk	21	*			mon	hi
o,	death certificate be executed e attending physicien and of for use as the burial-transit	Exa	resulting in death) Last	Due to (or as	a conseque	ence of):			100					C / A	1
8760,	e be sicie e bur	cal		0. (020	nas	ul	1/7	NES	Run	1/5			400	
9	ificat g phy as th	Physician/Medical				1	1	/-//							
Вох	thet the death certific ed by the attending p detached for use as	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						**		2	23d. Date of de	ynevil	
	death e atte d for	Cla	in the past 12 months? 1 ☐ Yes 2 Ø No	1 ☐ Live birth 4 ☐ Pregnant at]Ect <i>o</i> pic pr] Other (sp						Month	Day Yes	ar
o.	t the	hys	9 Unknown	9∐ Unknown											
ď.	law requires thet the es been signed by th 2 should be detache	by P	Part II. Other significant conditions of	ontributing to death bu	ut not result	ting in the ur	nderlying c	ause give	en in Part I.		23e. Did 1	tobacco u	se contribute to	o the cause of dea	ith?
Vital Records,	aquire en sig										10	Yes 2	No 3∏Pi	robably 4 Duni	known
ပ္တ	aw re	Completed									24a. Was		24b. Were at	utopsy findings av	aılable
æ	The lay	mo										ormed?	death?	completion of cau	se of
ta	an: tifice or. p	0	25. Was case referred to medical						26 Place	of Dont	1 Yes	2 No	1 Tes	2 M No	
5	Physician: r this certificaral director, I	To B	examiner? 1 ☐ Yes 2 ⑤ No	Hospital: 1 ☐ Inpatie	ont 2 TE	R/Outpatien	it 3 DC	Othe	ar.				3 □Other (Spe	no.6.)	
ō	Physical of the services of th		27. Manner of Death	28a. Date of Injur (Month, Day		28b. Time of		28c. Injury Work			28d. Describe			cny)	
o	th. : Afte	ŧ.	1 Natural 5 □ Pending 2 □ Accident investigation		y Year)	Injury	м		(? Yes 2 🔲 !	No					
Division	Attending r death. ector: After y the fune	fice	3 ☐ Suicide 6 ☐ Could not b	286. Place of Inju	ury - At hon	ne, farm, str	eet, factory	, office			28f. Location (Street and	d Number or Ri	ural Route Numbe	or,
á	ellor ellor Diri	Certification:	4 Homicide	building, etc	c. (Specity)						City or To	wn, State,)		
	To the Hospitel or Attending Physician: The within 24 hours efter death. To the Funeral Director: After this certificete his completely filled in by the funeral director, pege		29a. Certifier 1 Cartifying Pt	ysician: To the best of	of my know	ledge, death	occurred	at the tim	e, date an	d place,	and due to the	cause(s)	and manner as	s stated.	
	the H hin 24 the Fi	edical	one)	niner: On the basis of and manner sta	examination	on and/or in	vestigation,	, in my o _l	oinion, dea	th occurr	ed at the time,	date and	place, and due	e to the cause(s)	
	To t To t	Σ	29b. Signature and title of fertifier	011			290	c. License	number	111	10		e signed (Mont	h, Day, Year)	
			Am	set las	Visi	= M			DO	141	17	1-	3-0	6	
			30. Name and address of person who	completed on use of de	eath (Item :	23а) (Туре,	Print)			1.0	1	-			
75-			James P. Jan	boe / 2/4035	Thre	ee Not	ch Ro	oad,	Ho11	ywoo	d, MD 2	20636			
3	Sta		31. Date filed (Month) Day, Year).	32. gistra	ar's Signatu		ment.	,							
7	Registr	ar	S S MAL	3005	1	1	10.5	•							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 1 - For Stete Registral Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** 13:52 Charles Hamilton Slick Jr. 6, 2006 January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Hospital Washington Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ★M 2 ☐ F 75 May 21, Director Maryland 217-28-5871 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b County 10a State 1 X Yes 2 □ No Director Maryland Washington Smithsburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 47 North Main Street 21783 U.S.A. Funera Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1⊠Yes 2□No Army 1 X Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: If Yes, Give Year or Dates: 52-54 þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Menial Hygien.
Important: If item 27 is marked other that any injury or other traumatic. Teacher 5+ Board of Education 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Hamilton Slick, Sr. Susan May Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph A. Slick (Brother) 49 N. Main St. P.O. Box 17 Smithsburg, MD 21783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State January 10, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) Cavetown Cemetery 2006 Cavetown, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee J.L. Davis Funeral Home Mo14/4 12525 Bradbury Ave. Smithsburg, Maryland 21783 Je Hice AVIS 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) entre arrhythme Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Figure that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant

Physician /Medical Examiner

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Completed

Be

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Certification:

attending physician

the

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certificate has

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a Hospital or Attanding Pl 24 hours after death. a Funaral Diractor: After th

24 hours a

within 2 tha

be executed

Box 68760

P.O.

Division of Vital Records,

itam 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, It was load Examiner must be notified at

o filed within 72 hours after de I Hygiene. Other then "natural", or Itam

Baltimore, Maryland 21215-0036

the Maryland

death

23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

Day

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4€ Onknown

23e. Did tobacco use contribute to the cause of death?

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

in the past 12 months? 1 ☐ Yes 2 ☐ No

9 Unknown

24a. Was an autopsy 2 No 24b. Were autopsy findings available prior to completion of cause of death?

26. Place of Death (Check only one)

2□ No 1 ☐ Yes

25. Was case referred to medical examiner? Hospital: 1 ■Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 Yes 2 No 27. Manner of Death 1 Natural

4 Homicide

29a. Certifier (Check only one)

5 Pending investigation 2 Accident 6 Could not be 3 🗌 Suicide

28a. Date of Injury (Month, Day Year)

28c. Injury at Work? 28b. Time of 1 ☐ Yes 2 ☐ No

1 🗲 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29c. License number 0050362 29d. Date signed (Month, Day, Year)

anton 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Cantone Smithsburg Family Practice 22911 Jefferson Blvd. Smithsburg, MD 21783 31. Date filed (Month, Day, Year)

State Registrar

JAN 13 2005



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					Otato of Mi	ai yiai i	Certifica				-	Reg. No.	6 (105	69
			1. Decedent's Name (First, M	fiddle, Las	st)						2. Date of De Month	ath Day	Year	3. Time	of Death
н	Physici /Medic		Mae	Le	eotta	Sn	nith				Jan 6,	2006		9:58	am
1	Examin		4a Facility Name (If not insti						-		ocetion of Death				
			Devlin Manor						Cumbe			Allega			
	Funeral Director		5. Social Security Number 217-10-1218 Usual Residence of Deceder		ПМ ОПЕ	e (In yrs. I 16	last birthday) If Un Yrs. Month	der 1 Year ns Days	Hours	Min.	8. Date of Bird (Month, Da Nov 30	y, _{Year)}), 1919		Intry) AD	e or Foreign
	puel #	-	10a. State 10b. Co			10c. City	, Town or Location					· · · · · · · · · · · · · · · · · · ·	1		City Limits
	Mary Figh	ţ	MD All	egan	у		Cumberla	nd						1 □ Y6	es 2□No
	r 28s	9	10e. Street and Number				10f.	Zip Code				10g. Citizen of	What Coun	itry?	
	th wit	Funeral Director	130 E. Elder S	Street	t			:	21502			US	3A		
	ems er m	ne	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U,	S. 13. Was De	cedent of I	dispanic Original	gin? (Sp	ecify Yes or No Rican, etc.)	- 14. Rad Bla	ck, White,		
020	be filed within 72 hours efter death with the Marylend ital Hygiene. Id other then "netural", or Items 23a or 28s-f show event, the Modical Examiner must be notified at	þ	1 Never Married 2 3 Widowed X Divo		1 ☐ Yes 2 ☐ If Yes, GiveX Year or Dates:	No		2 ∕ No				Specif	white		
5-	72 h	Completed	15. Dec (Specify only h	edent's Ed ighest gra	ucation de completed)		16a. Decedent's U (Give kind of life. DO NO	sual Occup work done	oation during most	t of work	ing	16b. Kind of B	usiness/Ind	dustry	
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d 2	filed with Hygiene. ther ther int, the N		12 17, Father's Name (First, Mic	ddle. Last)			laborer		18. Mothe	er's Name	e (First, Middle,	Celan		orp.	
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<u>Z</u>	은 D E F	F	19a. Informant's Name/Rela		Туре, Print)		19b. Mailing Addr	ass (Street							
ž	nd 2 alth e 27 ts r tra		Barbara Proff	itt	niece		Rt. 2 Box	x 409			Ridge	ley	WV	/ 267	53
ē,	_ = = = =	ı	20a. Method of Disposition			20b. P	lace of Disposition (i	Vame of or other pla	ce)		Date	20c. Location	City or To	wn, State	
E	Page nent c nrt: If iry or		1 ☑ Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth				rest Memoria			1	1/9/2006	Cumbe	rland		MD
Baltimore, Maryland 21215-0020	permit. Pages 'Department of H Important: If ite any Injury or ot once.		21. Signature of Funeral Ser	vice Licen	See ///	1//	1, S	carpell		al Ho	me, PA	land, MD	24502		,
			23a. Pari1. Enter the diseas shock, owneart failure.	e, or com	plications that cause	d the death	n. Do not enter the n	node of dyi	ng, such as	cardiac	or respiratory a	rrest,	21502	Approxim Interval E	nate
	Physician		shock, or heart failure.	List only	one cause on each I	ne.							1	Onset an	nd Death
	/Medical		Immediate Cause (Final disease or condition		End	at.	Denis	- 2e	merca	the				19/1	-
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	icate be executed physician and s the buriel-transit	Examiner	Sequentially list conditions,		V		r as a consequence								
68760,	be exician buriel		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1	c								i		
387	phys phys s the	edical	that initiated events resulting in death) Last	1		Due to (or	r as a consequence	of):					1		
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of Vital Records,	The law requires that the death certificate be executed ate has been signed by the ettending physician and page 2 should be deteched for use as the buriel-transit	Completed										an autopsy ormed?	av	ere autops ailable prid mpletion o death?	
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B			25. Was case referred to me	dical			· · · · · · · · · · · · · · · · · · ·		26 Place	of Deat	th (Check only		1		
⋚	Physician: this certific	To Be	examiner?	Julian	Hospital: 1 ☐ Inpati	ent 2 🗆	ER/Outpatient 3□	DOA Ot	her			dence 6 □Oth	ner (Specif	v)	
	g Phys er this eral di		27. Manner of Death		28a. Date of Inju		28b. Time of Injury	28c. Inju Wo				how injury occu			
Ö	Attending or death.	atlo		ending vestigation		ly rear/	М		Yes 2□	No					
Division	or Atter efter des Director	Certification:	3 ☐ Suicide 6 ☐ C 4 ☐ Homicide	ould not be etermined	200. Flave 01 III	jury - At ho tc. (Specif)	ome, farm, street, fac y)	tory, office			28f. Location (City or To	Street and Num wn, State)	ber or Rura	ıl Route N	lumber,
	To the Hospital or Attending Phwitin 24 hours efter death. To the Funeral Director: After thi completely filled in by the funeral	edical C	29a. Certifier 1 Cer (Check only 2 Med	tifying Ph IIcal Exan	ysician: To the best niner: On the basis of and manner si	f examina	wledge, death occun tion and/or investigat	ed at the ti ion, in my	ime, date an opinion, dea	nd place, ath occur	and due to the red at the time,	cause(s) and m date and place,	anner as s and due to	tated. the caus	e(s)
	o the	₩.	29b. Signature and title of co	ertifier				29c. Licen	se number			29d. Date signe	ed (Month,	Day, Year	r)
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	'n		30. Name and address of pe	V -		death (Item	n 23a) (Type, Print)					/			
	7		AJBOILTAG			127'1		200	rle	67.	رد د	502			
	Sta Regist		31. Date filed (Month, Day,		92. Regist	rar's Signa									

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 1 tems 7,16b per fh 9851 1-13-06 vt. State of Maryland 7 Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 1:51 AM 2006 January Robert James Smith 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Washington County Hospital Washington Hagerstown 8. Date of Birth (Month, Day 7-3-47 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Mary land 1**∑**M 2□F 58 212-54-4572 Yrs. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Morgan Berkeley Springs 1 ☐ Yes X☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1020 Silvers Lane 25411 U. S. A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2√ No Specify: Specify:White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Carpentry Elementary/Secondary (0-12) College (1-4or 5+) Carpenter 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unknown Verniece Smith Gray 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1020 Silvers Lane, Berkeley Springs, WV 25411 Earline Smith 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Cedar Lawn Cemetery 1-6-06 Hagerstown, MD 21. Signature > Fune I Service Live 22. Name and Address of Facility Hunter-Anderson Funeral Home 36 S. Green St., Berkeley Springs, WV 25411 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final neumonia disease or condition resulting in death) Due to (or as a consequence of): Failnyp Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Dia beta Due to (or as a consequence of 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9☐ Unknown

Physician /Medical Examiner

Physician

/Medical

Director

Completed by Funeral

Be

10a. State

WV

Examiner

Funeral

Director

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "naturel", or iteme 23e or 28e-f ehow arry injury or other traumatic event, the Medical Examinating the rectified at our

Baltimore, Maryland 21215-0036

the death certificate be executed

Examine certificate has been signed by the attending physicien and rector, page 2 should be detached for use as the burial-transit Physician/Medical ð Completed : After this certifical funeral director, r Be Certification: To 24 hours after death.

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician:

To the

filled in by

within 24 ho To the Fune completely fi

Medicai

State Registrar IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

25. Was case referred to medical

5 Pending investigation

6 Could not be determined

1 Yes 25 No

examiner'

27. Manner of Death

2 Accident

3 Suicide

4 Homicide

1 Natural

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an

autopsy performed 2 XNo 1 ☐ Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred

1 Tes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number

224

D. [2323

29d. Date signed (Month, Day, Year)

Itra. Md

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1126 dsilm () ral

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day Year)

32. Registrar's Signature

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year)

			For State Registrar	State of N	Maryland / Dep <i>Ce</i>	artment of H			giene))(5 00671
	Physicia		Decedent's Name (First, Middle, Helen R. Scho					2. Date of Da. Month Januar	ath Day	Year -006 //:30 A M
	/Medic Examin		4a. Facility Name (If not institution, Calvert Manor H	give street and numbe	r)	4b. City, Town, or Rising			4c. County Ceci.	of Death
2	Funeral Director		206-12-0023	5. Sex 7. / 1 ☐ M 2 ☐ F	Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		y, Year)	9. Birthplace (State or Foreign Country) Pennsylvania
	Maryland -f ehow	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Cecil		10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes ※XXNo
	h with the	al Direc	10e. Street and Number 15 Schoch Drive			10f. Zip Code 21901			10g. Citizen of W United S	
036	72 hours after deeth with the Maryland Insturat; or Iteme 23e or 28e-f ehow dicel Examinat must be indiffed at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marrie 3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Force 1 Yes 2 filt Yes, Give Year or Dates	s? No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? an, Mexican, Pu Specity:	(Specify Yes or No erto Rican, etc.)	Black	- American Indian, c, White, etc. White
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural; or iteme 23e or 28a-f show appring to other traumatic event, it is Medical Examinat must be indiffed at an	Completed	15. Decedent's (Specify onfy highest Elementary/Secondary (0-12)		(Give life.	dent's Usual Occup s kind of work done DO NOT use retired keeper	during most of v	working	16b. Kind of Bu	siness/Industry g Manufacturing
/land	ould be filed Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, L. James J. Murray	as ()			Blanch	Name (First, Middle, e Gillisp	oie	
, Mar	and 2 sho leelth and m 27 le ma		19a. Informant's Name/Relationshi Robbie Miller/da			ren Drive		g Sun, Ma	ryland 2	21911
Baltimore,	it. Pages 1 rtment of H rtant: If ite njury or oti		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (So		saint's Paul Cem	matory or other place Peter and etery	20	uary 5,	Springf: Pennsylv	ania
Ba	Dermi Depa Impo any is		23a. Part1. Enter the disease, or o	omplications that caus	1	27 South	Main St		th East	Maryland 21901 Approximate
	Physician /Medical Examiner		shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	a. Re	line.					Interval Between Onset and Death 5 months
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O. Box 68	ne death certifi the attending p hed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown		2 Fetal death 3 at time of death 5	□Ectopic pregnancy	,		23d. Date Mor	e of delivery hth Day Year
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Division	ath. or: After	Certification:	1 Majural 5 Pending 2 Accident investigs 3 Suicide 6 Could not 4 Homicide determin	ot be 28e. Place of	Injury - At home, farm, si	M 1	yat k? Yes 2 □ No	28f. Location (er or Rural Route Number,
ā	To the Hospital or Atte within 24 hours efter de To the Funerel Directo completely filled in by th		29a. Certifier 1 Certifying	Physician: To the be	etc. (Specify) st of my knowledge, deas of examination and/or in	th occurred at the tir	me, date and planting	ace, and due to the	cause(s) and mai	nner as stated.
	To the H within 24 To the F complete	Medical	29b. Signature and little of certifier	and manner	stated.	29c. Licens			29d. Date signed	(Month, Day, Year)
7	8		30. Name and address of person w	tho completed cause of	of death (Item 23a) (Type	Print)	Ellto	n M.	I an word	3, 2006
i de	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 3 2006	See 32. Regi	In death (Item 23a) (Type Lasons strar's Signature	ر عادار ه	- 1/2: 0			

CPM 06-001: Carolyi	31 n Sprag	ue	Unpend item#23a,27,28a	ype or Prir F1, pen E, G8 State of Ma	It in Bla 51,1/25/ arvland /	ck Inc Of III	elible lnk .	. Ensure Al	I Copies A	Are Legi	ible.	10672
			1 = For State Registrar	Oldio or in	ary tarror		ificate of			g. No.		0012
	Dhysiei		1. Decedent's Name (First, Middle, Last,						2. Date of Death Month			3. Time of Death
	Physicia /Medic	al	Carolyn Ann Spra				4h Cih. Tour	or Langting of Dogsth	January	05,	2005	18:14 M
	Examin	er	4a. Facility Name (If not institution, give 2507 North Charles	Street,	2nd fl	Loor		imore		4c. County	OI DOAIII	
6913	Funeral Director		023-02-3010	7. Ag	e (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, NOV • 9	Year) 1964	Country	ce (State or Foreign y) 7aii
9	Maryland 8-f ehow	tor	Usual Residence of Decedent 10a. State 10b. County Maryland		10c. City, To	own or Loc		timore			100	d. Inside City Limits 1 √2 Yes 2 □ No
	th with the 23a or 28	al Director	10e. Street and Number 2507 N. Charles S	treet			10f. Zip Code	21218			.s.A.	
36	rs after dea I', or iteme xeminer m	by Funeral	11. Marital Status ★☆Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 H If Yes, Give Year or Dates:			as Decedent of H Yes, specify Cub	Hispanic Origin? (Spean, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ce - Americar ck, White, et by: Wh	
Baltimore, Maryland 21215-0036	permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if item 27 is marked other then "natural", or iteme 23s or 28e-f ehow eny injury or other traumatic event, the Medical Examinal must be nutified at ODGs.	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	ication		life. D	ent's Usual Occupind of work done O NOT use retire	· .	ing	6b. Kind of B	N/A	istry
and 21	l be filed v nta! Hygie ed other t	Be	17. Father's Name (First, Middle, Last) Albert Tilden Sp	raque, II	I		JICMP101	18. Mother's Name	e (First, Middle, M Lee Kohl			
Maryli	d 2 should th and Mei 7 is mark traumatic	٦ ٢	19a. Informant's Name/Relationship (7) Jennifer Zwiebel	/pe, Print)			Address (Street vondale	t and Number or Rur. Court. B	al Route Number, Briarclif	-		
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alti	mit. Poartme		21. Signature Juneral service Licens		17		In Crema Name and Addre		ohn M. Ta			Maryland L Home
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	the Hosp hin 24 hou the Funer upletely fill	Medical	(Check only 2 Medical Exam		of examination		estigation, in my	ime, date and place, opinion, death occur	red at the time, da		and due to t	the cause(s)
	T with T of D		29b. Signature and title of certifier	ull, MD				O.C.M.E.		January		
			30. Name and address of person who of	hall, MD		111		reet, Balt	imore, 1	Marylar	nd 2120	01
,	Sta Regist	_	31. Date filed (Month, Day, Year) JAN 1 0 2	32. Project	rar's Signatur		book					

DEANA M. STILLWELL Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Unpend item#2, 23a, 27, perME (852, 2/9/06 TT)

State of Maryland / Department of Health and Mental Hygiene () () 06-0012 RKD State
Registrar Amended item #2/wichd/1-4-06/Qutificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Jan. 1, 2006 3. Time of Death 2. Date of Death Month Day **Physician** Deana Marie Stillwell JANUARY 1, 200**56** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SALISBURY WICOMICO 230 NEWTON STREET If Under 1 Year
Months Days 7. Age (In yrs. last birthday) 35 8. Date of Birth

(Month. Day Year)

5/31/1970 If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number **Funeral** 1 ☐ M 2 🛂 F Months Hours Louisiana 433-29-0432 Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show or than "natural", or iteme 23a or 28a-f sho the Medical Examinar must be notified at 1X Yes 2 □ No Directo Maryland Wicomico Salisbury 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21801 USA 230 Newton St. death Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nant of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ite ury or other traumatic event, the Medical Examina 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Herman O'Brien Mary Estenson ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Holly Nicole Brumbley/daughter 403 E. Lincoln Ave., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Depertment of IImportant: if ite
ony injury or ot 1 ☐ Burial 2 ☐ Stremation 3 ☐ Removal from State 1/3/06 Salisbury Crematory Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lights Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest speck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cardiomegaly with Biventricular Dilation /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physicien and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Exam Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f Division of Vital Records, P.O. 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 3 ☐ Probably 4 Mnknown 1 Yes 2 No Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2 No page 2 s certificate Yes 2□No After this certification funeral director, it 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 \square Nursing Home 5 \square Residence 6 XOther (Specify) SCENE 1X Yes 2 □ No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) ŝ 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier JANUARY 2, 2006 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO 111 PENN STREET BALTIMORE MARYLAND 21201

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 0

2006

ORIGINAL

32. Registrar's Signature

			1 - For State Registrar	State of Mar			Health and	Mental Hyg	iene 19.4006	00674
	Dhamia		1. Decedent's Name (First, Middle, L.	ast)				2. Date of Deat		3. Time of Death
	Physic /Medi		HARRIET	DEY		SMIT	14	Jav	Day Year	13=10 M
	Exami		4a. Facility Name (If not institution, gi			4b. City, Town,	or Location of Deal		4c. County of Death	1.13-10
			HARFUND METHON				EDE GR	ALE	HARFO	~0
	Funeral Director			Sex 7. Age (1 ☐ M 2 🐧 F	In yrs. last birthday 84 Yrs.	Months Days			Year) 9. Birtho Cour New New 1	place (State or Foreign http) Jersey
	pur *		Usual Residence of Decedent 10a. State 10b. County	1	On City Town and					
	filed within 72 hours after death with the Maryland Hygiene uther than "neturel", or Items 23a or 28a-f show ent, the Mydical Examinar must be notified at	ō	MD Harfo		oc. City, Town or L Aberdee				1	0d. Inside City Limits 1 Yes 2 No
	288-	ect	10e. Street and Number							
	with Sa or	Funeral Director	359 Woodland Gr	een Ct.		10f. Zip Code 210	01	1	Og. Citizen of What Cour U.S.A.	ntry?
	leath ns 2:	era	11. Marital Status	12. Was Decedent Eve	er in U.S. 13	Was Decedent of	Hispanic Origin? (S	Consider Voc. or No.	14. Race - Americ	on Indian
(0	r Iter	F	1 ☐ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2X No	13.	If Yes, specify Cut	Hispanic Origin? (S pan, Mexican, Puer	to Rican, etc.)	Black, White,	etc.
93	el', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify: Whi	te
2-0	72 hc	Completed	15. Decedent's E (Specify only highest gr	ducation	16a. Dec	edent's Usual Occu	pation		16b. Kind of Business/Ind	
2	ithin	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	during most of wordd)	rking		
7	led w lygier her th	S	12	0	Cler	k typist			Medical	
and and	2 should be filed within 72 hours after death w and Mental Hygiene. is marked other than "neturel", or Items 23a 'eumetic event, the Mydical Examiner mast	Be	17. Father's Name (First, Middle, Last Jason Dey)				me (First, Middle, N	faiden Surname)	
Yla	should ind Men ind marka umartic	2					1	Newman		
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylar it of Health and Mental Hygiene. If item 27 is marked other than "neturel", or Items 23a or 28a-f show or other treumetic event, the Mydical Examinar must be notified at		19a. Informant's Name/Relationship George E. Smith	Type, Print) (Husband)	19b. Mail	ing Address (Street	t and Number or Ru Green Ct		city or Town, State, Zip deen, Maryla	
	permit. Pages 1 and 2 Department of Health Importent: If item 27 i any injury or othar tro once.		20a. Method of Disposition						Oc. Location - City or To	
20	Pages nent of l int: If it		1 Burial 2 Cremation 3			osition (Name of ematory or other pla	1 /3			
Baltimore,	permit. Pag Department Importent: I any injury o	1	* 4 ☐ Donation 5 ☐ Other (Speci 21. Signature of Funeral Service Lice			ris & Co			West Chester	r, PA
Ba	Depa Impo any ii		Tes o	100-11	7	Tarring-C berdeen.	argo Fune Maryland	ral Home 21001-	3380A.	
	- 4		23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused the						Approximate
	Pnysician :	1	Immediate Cause (Final disease or condition		+ A S C J	. ^				Interval Between Onset and Death
	/Medical		resulting in death)	a					-	
	Examiner		Sequentially list conditions	b						
7	ס ≒	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	onsequence of):					
V	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
8760,	be executed sician and burial-transit			Due to (or as a co	onsequence of):					
687	ate hy:	dical		d						
Вох	eath certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p	pregnancy				004 5/	
B	death atter	ciar	in the past 12 months?	1 Live birth 2 ☐ 4 Pregnant at tim	Fetal death 3	☐Ectopic pregnance ☐ Other (specify)	у		23d. Date of deliver Month	ry Day Year
0	at the de by the stached	Physician/Mec	9 Unknown	9□ Unknown						
s, D	The law requires that the te has been signed by th bage 2 should be detached.	by P	Part II. Other significant conditions of	ontributing to death but n	ot resulting in the u	inderlying cause giv	en in Part I.	23e. Did toba	acco use contribute to the	e cause of death?
ğ	w require been sig should b		Rheimin	d Arthr	mhs			1 ☐ Yes	2 □ No 3 □ Proba	ably 4 Unknown
၁၁	e law re has be je 2 sho	ompleted	Dichetes 5	Tellihs T	YPUT			24a. Was an	24b. Were autop	sy findings available
		EO.						autopsy perform	ed? death?	pletion of cause of
ita	Physicien: This certifical ral director, p	BeC	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only one		2040
× ×	ys dii	2	1 (Yes 2 No	Hospital: 1 ☐ Inpatient	2 R/Outpatier	nt 3 DOA Oth	er: 4 Nursing H	ome 5 Residen	ce 6 □Other (Specify)	
	ding Ph h. After th funeral	on:	27. Manner of Death 1 ANatural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	28b. Time o	f 28c. Injur Wor		28d. Describe how		
sio	Attending or death. ector: After by the funer	catl	2 Accident investigation			M 1 🗆	Yes 2 □ No			
Division	I or Attend after death Director: /	ertification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, str Specify)	reet, factory, office		28f. Location (Stre City or Town,	et and Number or Rural State)	Route Number,
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	OL	70a Cartifier	voicies 7 · · ·						
	a Hospital 24 hours a Funerel etely filled	edical	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best of mainer: On the basis of exa and manner stated.	amination and/or in	h occurred at the tir vestigation, in my o	ne, date and place, pinion, death occur	and due to the cau red at the time, dat	se(s) and manner as sta e and place, and due to	ited. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		•	29c. Licens	e number	290	d. Date signed (Month, D	Pey, Year)
)			1 Gmarsh	and Am	· m.	0 0	21809		ANIST 20	
			30. Name and address of person who	completed cause of death					1710 1 20	00 "
	12		Ganesh PrabhuO							
	Sta Registra	_	31. Date filed (Month, Day, Year) JAN 0 6	32. Registrar's	Signature	Serti				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** TANUARU 1226 NM Sharon Ann Smith Ol ZOULA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yead 956 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕅 F Months Days Hours Min. 49 Director 219-66-2043 November 29 Pennsylvania Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director Maryland Washington Hagerstown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Itame 23a 412 Vermont Ave. 21742 Funeral U.S.A.12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 72 hours after 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2X No Specify: δ Specify: 3 Widowed 4 Divorced White nature 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7: h and Mental Hygiene. 7 is marked other then "n Elementary/Secondary (0-12) College (1-4or 5+) 12 Assistant Manager College Bookstore 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elvin R. Smith Ruby M. Toms 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) is 1 and 2 s of Health an item 27 is Sheila M. Boyer (Sister) 13622 Overhill Dr. Hagerstown, Maryland 21742 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State permit. Pages t Department of H Important: if ite eny injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State January 5, 4 ☐ Donation 5 ☐ Other (Specify) Brown Cemetery 2006 Foxville, Maryland 21. Signature of Funeral Service Licensee M01414 22. Name and Address of Facility J.L. Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Maryland 21783 AUIS Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner f Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events Due to (or as a consequence of) Examine burial-transit be executed and resulting in death) Last Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy page 2 should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 ☐ Other (specify) Records, P.O. the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 ☐ No Division of Vital 1 Yes 2 No 25. Was case referred to medical 26. Place of Death Check only one examiner? Cther: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending Injury investigation М 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one ature and title of certifier 29b. Siggl 29c. License number 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 30 111 IIIIn medi 31. Date filed (Month, Day, Year) 35. Registrar's Signature State Registrar 1 0 2006

			1 - For State Registrar	State of M	laryland				lealth and Death	Mental H	lygiene Rog. No	000	00676
	, N. S. S.		Decedent's Name (First, Middle,	Last)						2. Date of	Death		3. Time of Death
	Physici	_	Ping	Kang S	hen					Janua	rv 2.	2006 Year	10:00 a.m.
	/Medic Examir		4a. Facility Name (If not institution,				4b. City	, Town, or	Location of Dea			. County of Deat	
	LAdimii		Bayside Ca	re Center				Lavi	ngton Pa	rk		St. Mar	
12	Funeral	JĮ.L			ge (In yrs. la	ast birthday)		er 1 Year	If Under 24 Hr	s. 8. Date of	Birth	9. Birt	holace (State or Foreign
30	Director		021-32-5120	1 8 M 2□ F	88	Yrs.	Months	Days	Hours Mir	Oct.	Day, Year,		na
	D.		Usual Residence of Decedent									, , , , ,	
	rylan how		10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
	e Ma	cto	Maryland St	. Mary's				Dra	yden				1 ☐ Yes 2 € No
	d within 72 hours after death with the Maryland Jione. I than "netural", or Iteme 23a or 28a-1 ehow I're Medical Examirae must be notified at	Director	10e. Street and Number				10f. Z	ip Code			10g. Ci	tizen of What Co	ountry?
	23a		19510 Pris	tine Way				20	630		Un	ited Sta	ites
	e m m	Funeral	11. Marital Status	12. Was Decedent Armed Forces			Was Dec	edent of H	ispanic Origin? (in, Mexican, Pue	Specify Yes or	No-	14. Race - Ame Black, Whit	
9	afte or it	正	1 Never Married 2 Marrie						Specify:	,		Specity: Asi	
8	ural',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:								opeony. 1103	
5	72 h	Completed	15. Decedent's (Specify only highest	Education grade completed)	ŀ	16a. Dece (Give	dent's Us kind of w	ual Occup ork done	ation du <i>ring</i> most of wi f)	orking	16b. k	(ind of Business/	Industry
21	within ene. than "	ld m	Elementary/Secondary (0-12)	College (1-4or	5+)	life.			1)				
2	illed within Hygiene. other than		47 Fab. 4 May 6 10 11 11 11 11	5+			Chem	ist	40 14-15-1-11		44-14-	Plastic	<u>: </u>
ī	o to to	Be	17. Father's Name (First, Middle, L						18. Mother's Na			n Sumame)	
Yes	should by nd Menta marked	2	Yi Jung Sh							Shiu Nar			
Maryland 21215-0036	0 6 6 6		19a. Informant's Name/Relationshi	60		less .						or Town, State, 2	
	s 1 and 2 f Health Item 27 other tra		Chyau N. S	nen / Son		P.O. I			Patuxenț	River		yland 20	
Ö	m Q		20a. Method of Disposition 1 ☐ Burial 2 🖺 Cremation	3 □Removal from State	Ce	emetery, cre	matory`or	other plac	1		20¢. L	ocation - City or	Town, State
Ë	Pa tmen tant: jury		4 ☐ Donation 5 ☐ Other (Sp.		Bri				Cre. 1-4		Cha	rlotte H	Mall, MD
Baltimore,	permit. Page Department Important: If eny Injury o		21. Signature of Fung al Service L	censee									ome, P.A.
	40 = • a		alle IV. Dr	VA M	1015							town, M	20650-0279
1			23a. Part 1. Enter the disease, or o shock, or heart failure. List of	emplications that cause my one cause on each	d the death	. Do not en	ter the mo	de of dyin	g, such as cardia	ac or respirator	y arrest,		Approximate Interval Between Onset and Beauty
	Physician		Immediate Cause (Final disease or condition		PAI	Min	10	wa.	loso	1			moult i
	/Medical		resulting in death)	Due to (or a	s a consequ	ience of):	2	7	1				,
п	Examiner		Sequentially list conditions.	ь	Yan	028	al	ic	Can	02/2			4) -
	ם ≅	ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	š a cons o qu	ience or):							
	e be executed /siclen and e burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c									
Ő,	e exe		1650///ing in dealiny case	Due to (or as	s a consequ	ience of):							
8760,	cate be executed obysiclen and the burial-transit	dlcal	1	d									
9	artific ing p	0	IF FEMALE:										
Вох	eath certific attending p	an/	23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth	e of pregnar 2 Fetal	ncy death 3[]Ectopic	pregnancy				23d. Date of del	
	ed at	SICI	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant a			Other (s				-	Month	Day Year
P.0	thet the de led by the a detached	Physician/M	9 □Unknown										
	8 5 8	b	Part II. Other significant condition	s contributing to death	but not resu	ilting in the u	nderlying	cause giv	en in Part I.				the cause of death?
pro	require been sig should b	Completed								1	☐ Yes 2	Pro 3 □ Pr	obably 4 Unknown
S	lawr as be 2 sh	ple								24a. W	as an itopsy	24b. Were au	stopsy findings available completion of cause of
ř	The la	E O								pe 1 ☐ Ye	erformed?	death?	2 No
Vital Records,	ician: Th certilicate rector, pag	· o	25. Was case referred to medical						26. Place of De	eath (Check on		<u> </u>	
† \	g is	To B	examiner? 1 ☐ Yes 2 🗗 No	Hospital: 1 ☐ Inpat	ient 2 🗆 8	ER/Outpatie	nt 3 🗆 🖸	OA Oth	er: 4 Nursing	Home 5□R	esidence	6 ☐Other (Spe	afy)
ا م	<u>a</u> + <u>e</u>		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inj (Month, D	ury av Year)	28b. Time o	f	28c. Injun Wor	y at	28d. Descrit	e how inju	iry occurred	
Division	Attending or death. ector: After by the fune	atlc	2 ☐ Accident investiga	ition	., ,		М		Yes 2 □ No				
ĬŠ	of or Attendate after death	tific	3 Suicide 6 Could no 4 Homicide determin	led 28e. Place of Ir	njury - At hor		reet, facto	ry, office			n (Street a Town, Stat		ural Route Number,
	ospital or A hours after uneral Dire ly filled in by	Certification;			, , , , , , , , , , , , , , , , , , , ,	,				2, 3/	, טומו		
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by		29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the besi	t of my know	wledge, deat	h occurre	d at the tin	ne, date and place	ce, and due to t	he cause(s	s) and manner as	stated.
	the H in 24 ihe F plete	Medical	one)	and manner s	tated.	on and/or in	vestigatio	п, яттіў О	pillion, ueath occ	Julieu at the tin	.e, uate an	o place, and due	rio ine cause(s)
	To the within 2: To the complet	Σ	29b. Signature and title of certifier	OI	0	11	2	c. Licens	e number	10	29d. Da	ate signed (Mont	h, Day, Year)
			An	nest la	N/Z	ENI		1	004	14	/	-3-8	26
			30. Name and address of person w	ho completed cause of	death (Item	23a) (Type,	Print)			1	-		
			James P. Jarb	oe, M.D., 2	4035	Three	Note	h Ro	ad, Holl	ywood,	Mary	land 206	36
	Sta		31. Date filed (Month, Dut), Yang	ZUUD 32/Regist	trar's Signat	ture	NI OFF						
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State of Maryland / Department of Health and Mental Hygiene 00677 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 8:06 A M January 5, 2006 Doris Lee Stouter /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Memorial Hospital Frederick 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1□M 2ĀF 79 ROCKY RIDGE, MD. Director AUG.13,1926 214-24-7337 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits id 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene.
27 is marked other then "natural", or items 23a or 28s-1 ehow traumatic event, the Medical Examinar must be realised at 1 ☐ Yes 2 No Director FREDERICK EMMITSBURG 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 16751A SCOTT RD. 21727 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LESLIE W. ဥ FOX BIRDIE TROXELL Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Important: if item 27 ie any njury or other trau 2009. CHARLES F. STOUTER/HUSBAND 16751A SCOTT RD., EMMITSBURG, MD. 21727 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Dogration 5 Other (Specify) NEW ST. JOSEPH'S 1/7/2006 EMMITSBURG, MD 21727 21. Signature of Fundral Service Licensee 22. Name and Address of Facility SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, MD. 21727 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death elete myscardial **Physician** /Medical Due to (or as a consequence of) Examiner House Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed physicien and s the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical attending ph IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month Day 4☐ Pregnant at time of death 5 ☐ Other (specify) P.O. the signed by 1 1 be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, ricate has been si 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? s certificate ! 1 ☐ Yes 2 ☐ No 1 Yes 2 No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) ၉ 1 Tyes 2 No funera! dir this 28a. Date of fnjury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No death. To the Hospitei or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fu investigation 2 Accident filled in by the 3 Suicide 6 Could not be 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and attle of contries 29c. License number 29d. Date signed (Month, Day, Year) D2281 JANUARY 5, 2006 5 30. Name and a sess person who sempleted cause of death (Item 23a) (Type, Print) 52 WATER ST., THURMONT, MD. 21788 BRAD COOPER 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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24a. Was an autopsy performed? 24b. Were autop performed? 24b. Were autop of completion of death?	MONTHS VEARS to the cause of dearobably 4□ Unknown
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25. Was case referred to medical examiner?	MONTHS VEARS It to the cause of dear robably 4 Unknown under und
examiner? 1 Yes 250 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)	MONTHS YEARS To the cause of dearobably 4 □ Unknown autopsy finding available prior to completion of cause of death?
27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred Work?	YEARS to the cause of dear robably 4 Unknown unique unique to completion of cause of dearn?
	YEARS to the cause of dear robably 4 Unknown unique unique to completion of cause of dearn?
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Exar To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours aftar death.

To the Funeral Director: Aft
completaly filled in by the fu

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

29a. Certifier (Check only one) Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number 33700 29d. Date signed (Month, Day, Year)

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

WILLIAMSPORT ST.

3,2006

State Registrar TED E. HOWE

31. Dete filed (Month, Pay, Year)

JAN 1 2 2006



	1 - For State Registrar 1. Decedent's Name (First, Middle, Lasi	State of Maryla		rtificate of L			g. No.	3. Time of Death
ician	_	•	Ellis	Vrooman		January	6°, 2006	11:35 AM
niner	4a. Facility Name (If not institution, give Buckinghams Choic		e Cente		Location of Death		4c. County of Fred	Death erick
al or	5. Social Security Number 6. Se 058-05-9754		rs. last birthday,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov 25,	^{Уөаг)} 1 908 Г	Birthplace (State or Foreig Country) ennsylvania
by Funeral Director	Usual Residence of Decedent 10a. State 10b. County		City, Town or L					10d. Inside City Limits
ector	Maryland Frederic	k	Adamsto					1 ☐ Yes 2 X XX
Dir	3122 Chartwell	Crescent		10f. Zip Code 217	10	= 10	U.S.A.	
by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give	1 U.S. 13.	Was Decedent of Hi If Yes, specify Cubar		ecify Yes or No- Rican, etc.)	14. Race -	American Indian, White, etc. White
ted b	15. Decedent's Edu	Year or Dates:	16a. Deca	dent's Usual Occupa	ition	1	6b. Kind of Busi	
Completed	(Specify only highest grade Elementary/Secondary (0-12) 5+	College (1-4or 5+)		kind of work done of DO NOT use retired, omemaker	luring most of work	ing	Own H	
Be	17. Father's Name (First, Middle, Last) Claude Alexa	nder Ell	is		18. Mother's Nam Gertrud	e (First, Middle, N e Mabel	,	
ဥ	19a. Informant's Name/Relationship (T			ng Address (Street a				
	John Neuenschwand	er/Brother-i	n-law 3:	122 Charty	well Cres	cent, Ada	mstown,	MD 21710
	20a. Method of Disposition 1 Burial 2 Cremation 3 I	Removal from State	cemetery, cre	natory or other place	9)		Oc. Location - Ci	•
	4 Donation 5 Other (Specify, 21. Signature of Funeral Service Licens			rg Cremato 2. Name and Addre				rg, Maryland
Н	23a. Part I. Enter the Isease, or comp shock, or heart fillure. List only o		0706 1	2. Name and Addre Secney and Ob East C	hurch St	., Frede	rick, MD	21701 Approximate
edicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cons	Sequence of):	insters	the last	leedy	9	Interval Between Onset and Death
Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time o 9 □ Unknown	etel death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	
þ	Part II. Other significant conditions co	ntnbuting to death but not	resulting in the u	inderlying cause give	n in Part I.		_	ute to the cause of death? Probably 4 □Unknown
Completed	Esteed fela	Clatin				24a. Was an autopsy perform	ed? dea	re autopsy findings available to completion of cause of th? Yes 2 □ No
o Be	25. Was case referred to medical examiner? 1 \sum Yes 2 \text{No} No	Hospital:	Перио	Othe		h Check only one	7.	
\vdash	27. Manner of Death 1 Patural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year	28b. Time of Injury	f 28c. Injury Work	at at	me 5 Resider 28d. Describe how		(Specify)
Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury · A building, etc. (Spe	t home, farm, st ecify)	reet, factory, office		28f. Location (Str. City or Town,	eet and Number State)	or Rural Route Number,
Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best of my liner: On the basis of exam and manner stated.	knowledge, deat ination and/or in	h occurred at the tim vestigation, in my op	e, date and place, inion, death occur	and due to the car red at the time, da	use(s) and mann te and place, and	er as stated. I due to the cause(s)
×	29b. Signature and title of certifier	Eliser	Ma	29c. License	number 3645	-/-	d. Date signed () January	Month, Dey, Year) 6, 2006
	30. Name and address of person who c	completed cause of death (I	tem 23a) (Type,	Print) 6+2	17.6			21701
State	31. Date filed (Month, Pay Year)	32. Registrar's Si	mature #	ON////11-	1	rerul,	2/100	11 101

Registrar

	Please Type or Print in Black in State of Maryland / Den	idelible Ink. Ensure All artment of Health and Me	3
	4 101	rtificate of Death	Reg. No. 006 00683
Physician	Decedent's Name (First, Middle, Last)	:	2. Date of Death Month Day Year 3. Time of Death
Physician /Medical	Mary Elizabeth Ward		January 03, 2006 6:30 am
Examiner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death Washington
Funeral	Reeder Memorial Nursing Home 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Boonsboro If Under 1 Year If Under 24 Hrs.	8. Date of Birth 9. Birtholace (State or Foreign
Director	216-03-1447 1□M 2∏F 94 Yrs.	Months Days Hours Min.	(Month, Day, Year) May 5, 1911 Maryland
and	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Le	ocation	10d. Inside City Limits
Mary Mary Mary	Maryland Frederick Ijamsv	/ille	1 ☐ Yes 2 🙀 No
vith the Ma	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
death with the Maryland ms 23e or 28e-f show rimus be cotified at neveral Director	2660 Urbana Pike	21754	U.S.A.
or Items 236	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R	ify Yes or No- lican, etc.) 14. Race - American Indian, Black, White, etc.
5-0036 72 hours a natural', o	3X Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	Specify: White
21215-00 ed within 72 hours then "set then "naturur it, tra Medical to the Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation be kind of work done during most of working	16b. Kind of Business/Industry
2121 2121 ad within griene. er then "	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired) nemaker	Own Home
ind 2 be filed tal Hygin d other event, the			(First, Middle, Maiden Surname)
Cxrdlaryland	John J. Burdette	Cora	King
Maryland Maryland d 2 should be filt th and Mental Hy 77 is marked oth treumatic event			Route Number, City or Town, State, Zip Code)
7 6 7 7	20a. Method of Disposition 20b. Place of Dispo	osition (Name of Da	sville, Maryland 21754
	Taxbunar 2 Cremation 3 Hemoval from State	matory or other place) cove Cemetery 1/7/9	
Baltimore, permit. Pages 1 a Department of Hes importent: if tem eny injury or othe once.	21. Signature of Funeral Service Licensee	2. Name and Address of Facility	
Z m #8 # 8	23a. Part 1. Enter the disease, or complications that caused the death. Do not en	olesworth-Williams : 6401 Ridge Road, Da	amascus, Maryland 20872
S	shock, or heart failure. List only one cause on each line.	ter the mode of Fing, such as cardiac or	respiratory arrest, Approximate Interval Between Onset and Death
Physician /Medical	Immediate Cause (Final disease or condition resulting in death)		CEVERAL YEARS
Examiner	Due to (or as a consequence of): CWent C & bs W.	ictive pulmonary	discase. Every WARK
P = 0	cause. Enter Underlying		ZA CINKY WILD
), executed in and ial-transit	Cause (Disease or injury that initiated events c.		
	Due to (or as a consequence of):		
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P.O. Box 68 hat the death certifical of by the attending phylicated for use as the Physician/Medi	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □	Dectopic pregnancy	23d. Date of delivery
O. E ine dea the definition of the att	in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown 9 ☐ Unknown	Other (specify)	Month Day Year
ords, P.O. requires that the defined signed by the incourable detached to the incourable detached the properties of the		underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
rds, quires the no signer and be defended by	Hypertension Alinal Fibrollation		1 Yes 2 No 3 Probably 4 Donknown
4) a a c	Alinal Fibrollation		24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of
Vital Rec elcien: The law s certificate has b lirector, page 2 s			autopsy performed? performed? death? l □ Yes 2 □ No l □ Yes 2 □ No
Vita icien: certific ector.	25. Was case referred to medical examiner?	26. Place of Death /	(Check only one)
Of \Physical directions of the second direction directions of the second direction directions of the second direction directions of the second direction direction directions of the second direction direction directions of the second direction direction directions of the second direction dir	1 Inpatient 2 EH/Outpatien		e 5 Residence 6 Other (Specify) 3d. Describe how injury occurred
ion nding ath. r: Afte e fune	1 Alatural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	of 28c. Injury at 28 Work? M 1 Yes 2 No	
Division of Vital Records, tel or Attending Physicien: The law requires the safter death. el Director: After this certificate has been signed ed in by the funeral director, page 2 should be ded in by the funeral director, page 2 should be deriffication: To Be Completed by	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office 28	3f. Location (Street and Number or Rural Route Number, City or Town, State)
Ditel o ours aft ours aft illed in			
Division of Vital Re To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	29a. Certifier 1 Tertifying Physicien: To the best of my knowledge, deat (Check only one) and manner stated.	h occurred at the time, date and place, an ivestigation, in my opinion, death occurred	nd due to the cause(s) and manner as stated. If at the time, date and place, and due to the cause(s)
To the within To the comple	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
		00062223	1/3/06
	30. Name and address of person who completed cause of death (Item 23a) (Type,		21712 201 722 7122
State	Dr Praveen Bolarum 340 Mills Street 31. Date filed (Month, Day, Year) 32. Begistrar's Signature	t, Magerstown, MD	21740 301-739-7100
Registrar	JAN 1 3 2006 American 18	seles	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 00684 State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** William Kenneth Warner January 1, 2006 2:00 РМ /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Accident Garrett Cherry Hill Assisted Living If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 17,1915 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**⊠** M 2□ F Months Days Hours Min. 90 Yrs. **Director** 217-10-5319 Maryland Usual Residence of Decedent 2 should be illed within 72 hours after death with the Maryland and Mental Hygiene.

Is marked other than "natural", or Items 23s or 28s-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinationst be notified at 1 ☐ Yes 2 X No Director Garrett Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 79 Old Blocher Road 21532 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify <u>გ</u> 3X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Foreman Textiles 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked oth any injury or other treumatic event once. Be Milton Warner ည Daisy Werner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda Garlitz/Daughter 341 Green Lanter Rd., Lonaconing, MD 21539 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Finzel Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) Jan. 4, 2006 Finzel, MD 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Liseasee P.O. Box 275, Grantsville, MD Approximate Interval Between Onset and Death Priysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner certificate be executed the burial-transit and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Dav 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 ☑Unknown 1 ☐ Yes 2 ☐ No peen 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? 2□ No 2 No 1 Yes ours after death.

nerel Director; After this certific.
filled in by the funeral director, or Attending Physiclen: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospitel o within 24 hours aff To the Funerel Di 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 03/01/2006

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

- 3 2006

31. Date filed (Month, Day, Year)

S.L. Sandhir, M.D., 48 Tarn Terrace, Frostburg, MD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amend it ems 200 per file 135 Health and Merital Hygiepe 16 16 5

					(Certifica	ate of	Death		Reg. No.	0 0	0000
			1. Decedent's Name (First, Middle, La:	st)					2. Date of		Year	3. Time of Death
1	Physicia /Medic	_	Lizzie J	. Yod	er				Ja		2006	6:30 P.
	Examin		4a Facility Name (If not institution, give	e street and number)				4b. City, Town	n, or Location of (Death 4c. County	of Death	
			1675 Dorsey H						sville		rett	
	Funeral Director		5. Social Security Number 3.17-54-8137 Usual Residence of Decedent	ex 7. Age (I	n yrs. last birth 81	Month	der 1 Year is Days		Min. (Monti	of Birth n, Day, Year) 26,1924	9. Birthpla Country Ind	ce (State or Foreign y)
	/land	ŀ	10a. State 10b. County		Oc. City, Town						100	d. Inside City Limits
	Man	호	Maryland Gar	rett	Gran	tsvi]	Lle					1 ☐ Yes 2 X Xo
-	r the	E	10e. Street and Number			10f. 2	Zip Code			10g. Citizen of V	What Countr	y?
	230 th	je	1675 Dorsey	Hotel Road	d		215	536		USA		
	8 5	E E	11. Marital Status	12. Was Decedent Eve Armed Forces?	or in U,S.	13. Was De	cedent of H	lispanic Origin an, Mexican, F	? (Specify Yes of Puerto Rican, etc	or No- 14. Rac	e - American	
21215-0020	filed within 72 hours after deeth with the Maryland Hyglene. ther than "naturel", or terma 23e or 28e-f ehow int, the Medical Examinar must be notified at	d by Funeral Director	1 Never Married 2√ Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:			≉≅No	Specify:		Specify	ν	ite
<u>2</u>	72 h	Completed	15. Decedent's Ed (Specify only highest gra		10	ecedent's Usine kind of	work done	during most of	f working	16b. Kind of B	usiness/Indu	stry
42	Althin	臣	Elementary/Secondary (0-12)	College (1-4or 5+)		ife. DO NOT		a)				
	Hygle Hygle Int, in		17. Father's Name (First, Middle, Last)		Н	omema	ker_	18 Mother's	Name (First Mi	HOTI ddle, Maiden Surnan		
Maryland	ould be Merkel I mrked of matic eve	Be		h D. Lehm	an					Helmutth	,	
<u>Z</u>	2 should be filed withir and Mental Hyglene. Ie marked other than eumatic event, the Mi	٩	19a. Informant's Name/Relationship (Aailing Addre	ass (Street			umber, City or Town,		Code) 2.1.5.2.6
S	permit. Peges 1 and 2 should be filed withir Department of Health and Mental Hyglens. Important: If Item 27 is marked other than eny injury or other treumatic event, the Mignes.	- 1	Milton J. Yo							d, Grant		
	Health Health Health other tr	1	20a. Method of Disposition		20b. Place of D	isposition (A	Vame of					
2	Peges nent of int: If Its iry or o		Surial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific		_	crematory o			1-7-0			D.A
Baltlmore,	permit. Pege Department of Important: If eny injury or pnce.	1	21. Signature of Funeral Service Licer		итлет	22 Name	and Addre	ss of Facility	M. Ray	Salsh Leckemby	Funer	al Home
Ba	Depring Peny	- 1	Dm. Raut		0375				203 No	rth Stre	et	
		-	23a. Part1. Enter the dissesse, or com	plications that caused the	dooth Do no			The second second second	Pa. 15			Approximate
	Physician /Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death)	a Metasi	fatte e to (or as a co O O or as a 20	nsequence of	nc.	rown) orig	gen	1	
Box 68760,	eeth certificate ba executed ettending physician and I for use as the burlat-trensit	Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	e to (or as a co							
P.O. E	at the deel by the ett	Physician	Part II. Other significant conditions o	ontributing to death but n	ot resulting in t	he underlyin	g cause giv	ven in Part 1.	23b.	Did tobacco use co		he cause of death?
Records,	law requires that the deeth c ies been signed by the ettend is 2 should be detached for us	Completed by							24a.	Was an autopsy performed?	avail	e autopsy findings lable prior to pletion of cause eath?
	W - 2	Ë								1 Yes 23%	10	Yes 2□ No
ā	ician: The certificate rector, pag	Be	25. Was case referred to medical					26. Place of	f Death (Check of	enly one)	Į.	
of Vital	S 00 0	P	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outp	atient 3	DOA Oth	ner: 4 ☐ Nursi	ing Home 5 🗗	Residence 6 □Oth	ner (Specify)	
	2 12 2		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		ear) 28b. Tir Inj		28c. Inju	ryat rk? ∣Yes 2⊡No	28d. Desc	ribe how injury occur		
Division	al or Atte s after de si Directo	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury building, etc. (- At home, farn Specify)	n, street, fact	ory, office			ion (Street and Numb r Town, State)	ber or Rural i	Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical (29a. Certifier (Check only one)	ysician: To the best of miner: On the basis of ex and manner stated	amination and/	death occurre or investigati	ed at the ti	me, date and popinion, death	place, and due to occurred at the t	the cause(s) and maine, date and place,	anner as state and due to t	ted. he cause(s)
	Withi To th	¥	29b. Signature and title of certifier	0		2	\mathcal{D}^{∞}		3/	29d. Date signe	od (Month, Da	ay, Year)
			Robin L. Bisse		124	ype, Print)			GRENTS	VIIIZ M	d 2	(536
	Sta Registr		31. Date filed (Month, Day, Year) JAN 1 3	2006 32. Redistrar's	Signature	Post						

		4	For Stete Registrar	ate of Maryland		artment rtificate			ind Mo		giene Reg. No.	06	0068	6
	Physicia /Medic	an	1. Decedent's Name (First, Middle, Last) HARRY, CHARLT	S AGRO)					2. Date of Dea Month	Day	Year 2006	3. Time of E	
	Examin	er	4a. Facility Name (If not institution, give street Horbor Hospitul	Center		Bal	tin	Location o		, in the second		ounty of Death		
- Sep	- Funeral Director		5. Social Security Number 6. Sex. 1218–18–1493 Usual Residence of Decedent	2 F 7. Age (In yrs. last	Yrs.	If Under	Year Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Da August	h y, Year) 12,1		lace (State or htry) ryland	Foreign
	Maryland	tor	10a. State 10b. County Maryland Baltimor	e Ba		ore H	igh1	ands				1	0d. Inside City	1
	h with the 23a or 28e	Funeral Director	10e. Street and Number 3017 Michigan Avenue			10f. Zip		227			10g. Citiz	on of What Cour		
980	s within 72 hours after death with the Maryland Jiene. I then "natural", or items 23a or 28e-f ehow The Medical Examinar must be notified at	þ	1 Never Married 2 Married	Nas Decedent Ever in U.S. Armed Forces? Yes 2 ☐ No f Yes, Give Year or Dates:		Was Decede f Yes, speci 1 Yes 2		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto F	cify Yes or No Rican, etc.)		Specify: Wh		
21215-0036	l within 72 liene. r then "nai	Completed	15. Decedent's Education (Specify only highest grade continuous Elementary/Secondary (0-12)		(Give life.	dent's Usual kind of wor DO NOT use Maste	k done di e retired)	u <i>ring m</i> ost		g		of Business/Inumbing	dustry	
nd	al Hyg	Be	17. Father's Name (First, Middle, Last)							(First, Middle,	Maiden S	umame)		
Maryland	Men Men arke	70	Giovannia A	gro Print)	19h Mailir	na Address	(Street a		fons		accia	tore Town, State, Zip	Codel	
-	12 7 is		Marlene A. Kreisel	(Wife)								Marylan		1
Baltimore	permit. Pages 1 and Department of Heeli Importent: If Item 2 eny Injury or other QDCE.		20a. Method of Disposition 1	cem	etery, crer Hil	natory or other of the Center	eter	у О	1-17	-06		ation · City or To klyn Pai		land
Ba	Depa Impo eny i			0922		Soutt				neral _B a	lome iltim	P.A. ore; Ma	rvland	2122
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one complications are complicated as the complex of the co	ons that caused the death. I	Do not ent	er the mode	of dying	, such as	cardiac or	r respiratory a	rrest,	,	Approximate Interval Betwo	een
*	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Respirato Due to (or as a consequen		tail	me	•					30 min	
<i>y</i> .	Examiner	ner	Securativity list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease of injury		Arrl	wth	mi	as					1 day	
	ate be executed hysicien end he burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Metastat Due to (or as a consequent		Lun	9—	Can	cer	•	_	-	i yeon	
8760	4 E E	edical	d	Congestiv	re	Hear	+	Fai	hure				1.5 day	} •
P.O. Box 6	The law requires thet the death certificate has been signed by the attending page 2 should be detached for use as i	Physician/Me	in the past 12 months?	if yes, outcome of pregnancy 1□Live birth 2□Fetal de 4□Pregnant at time of deat 9□Unknown	ath 3	Ectopic pre Other (spe					2:	ad. Date of delive Month		ear
	w requires thet been signed b should be deta	þ	Part II. Other significant conditions contrib	- 0		nderlying ca		n in Part 1. Di`seo	ue		obacco us Yes 2□	e contribute to the	ne cause of de	
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Vita	ysician: Th is certificate director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ital: 1 X Inpatient 2 ☐ ER	VOutnatier	at 3□ DO	Othe	-		(Check only o		☐Other (Specif	w)	
ion of	ding Ph h. After th funeral		27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation		Bb. Time of Injury		Bc. Injury Work		2	8d. Describe			77	
Division	i E # 2	Certification:	3 Suicide 6 Could not be 4 Homicide determined	8e. Place of Injury - At home building, etc. (Specify)	e, farm, str	reet, factory,	office		2	8f. Location (: City or To		Number or Rura	il Route Numb	er,
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier (Check only one) 1 🔀 Certifying Physici. 2 🗍 Medical Examiner:	n: To the best of my knowle On the basis of examination and manner stated.	dge, deat and/or in	h occurred a vestigation,	at the tim in my op	e, date and inion, deat	d place, a th occurre	and due to the ed at the time,	cause(s) a date and	and manner as s place, and due to	tated. the cause(s)	
	T Miles	M	29b. Signature and title of certifier Xianguan	& Sun M	D	100	License	number			_	signed (Month,		6
	2014		30. Name and address of person who comp Xicroguang Sun,		3a) (Type.					t, Bal	tim	re Mi	7 212	25
	Sta Registi		31. Date filed (Month, Day, Year) JAN 1 7 2005	32. Registrar's Signatur		200				, , , , , ,			•	100
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ORIGINAL

		•	For State Registrar	tate of Maryland / Dep Ce	artment of Health are	-	giene 06	00687
			Decedent's Name (First, Middle, Last)			2. Date of De		3. Time of Death
	Physicia /Medic		Susie B	. Andrei	NS	JANUAR	2 1 11 11 -1	04:35AM
)	Examin		4a. Facility Name (If not institution, give stre	11 2	4b. City, Town, or Location of C		4c. County of Death	10
			5. Social Security Number 6. Sex	N TOSFITAL 7. Age (In yrs Jast birthday	JAKTINOLE If Under 1 Year If Under 24		th 9 Birth	nplace (State or Foreign
	Funeral Director		236-36-2267 10M		Months Days Hours	Min. 8. Date of Birt	71977 108	+ Virginia
	pu.		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation		71000	10d. Inside Oity Limits
	Aaryla Febor	ō	More don't	Be 14				N Yes 2 No
	the h	Director	10e. Street and Number	Dani	10f. Zip Code		10g. Citizen of What Co	untry?
	th with	al Di	5920 Burges	SS Ave.	21214		USA	
	er dea	Funeral		Armed Forces?	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	n? (Specify Yes or No Puerto Rican, etc.)	14. Race - Amer Black, White	
36	rs afte	by Fi	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ∰No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: W	hite
215-0036	172 hours after death with the Maryland "natural", or Items 23a or 28a-f show clical Examinat must be multiped at	ted	15. Decedent's Educati	on 16a. Dece	edent's Usual Occupation	f working	16b. Kind of Business/l	ndustry
215	within 7 ene. than *r	Completed		College (1-4or 5+)	e kind of work done during most o DO NOT use retired)	i working	11 14	200
121	filed with Hygiene. Ither than		17. Father's Name (First, Middle, Last)	N/H F	TUMEMONE 18 Mother's	Name (First, Middle,	Maiden Sumame))/Y/C
Maryland	d la d	To Be	Ham Blo	VIDS	M	aru N	10hler	
ary	and Men is marke	-	19a. Informant's Na le/Relationship (Type,	Print) 19b. Mail	ling Address (Street and Number	or Rural Joute Number	er, City or Town, State, Z	ip Code) 21214
	es 1 and 2 of Health a fitem 27 is r other trai		James L. Ar	ndrews 592	O Burgess	Ave. Ba	Himore, II.	anyland
altimore,	Pages 1 ar nent of Hea int: If item ? iry or other	1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rem	20b. Place of Disposal from State	position (Name of ematory or other place)	Cap 17	20c. Location - Oty or	Town, Safete
I i i	permit. Pag Department Important: I any injury o		'4 Donation 5 □ Other (Specify) 21. gn re Fun ra Se e Licen e	Markey	Oct Cemetay	2006	Harkville	Maryland
Ba	permit. Departr Imports any inje		N XX A	9	1800 Harfurd	vans che	apel of M	nories,
			23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one	ions that caused the death. Do not er	nter the mode of dying, such as ca	irdiac or respiratory a	rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		VOCARDIAL IN	IFARCTIC	on	Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a consequence of):				
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<i>j</i>	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events					
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_	eath certific attending pl	/Me	IF FEMALE: 23c.	If yes, outcome of pregnancy			23d. Date of deli	NACV.
Box	death a atter d for u	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes ▷ No	4 Pregnant at time of death 5	☐Ectopic pregnancy ☐ Other (specify)		Month	Day Year
P.0	at the by the	hys	9 🗆 Unknown	9□ Unknown				
	law requires that the death certif as been signed by the attending 2 should be detached for use a:	by	Part II. Other significant conditions contrib	outing to death but not resulting in the	underlying cause given in Part I.		tobacco use contribute to Yes 2 □ No 3 □ Pri	
ecords,	w require been si should I	Completed				-		
Rec	sician: The law certificete has t irector, page 2 s	ldm				24a. Was auto perio	psy prior to o prmed? death?	topsy findings available completion of cause of
Vital	ysician: The is certificate hadirector, page	Be Co	25. Was case referred to medical		26 Place o	1 ☐ Yes of Death (Check only of	2 No 1 Yes	2 No
f∨i	> 0 0	To B	examiner? 1 Yes 2 No	pital: 1 ☐ Inpatient 2 ER/Outpatie	Other		dence 6 Other (Spec	city)
n of	ding Ph h. After th funeral		27. Manner of Death 1 V Natural 5 ☐ Pending	28a. Date of Injury 28b. Time (Month, Day Year) Injury	Work?		how injury occurred	
Division	Attending r death. ector: After y the fune	icatl	Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, s	M 1 Yes 2 No		Street and Number or Ru	ral Pouto Number
Di≺	after Direction by	Certification:	4 Homicide determined	building, etc. (Specify)	street, factory, onice		wn, State)	Tar Fronte Humber,
	Hospital 14 hours : Funeral I tely filled	iai C	29a. Certifier 12 Certifying Physic	an: To the best of my knowledge, dea	ath occurred at the time, date and	place, and due to the	cause(s) and manner as	stated.
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	ledical	one)	On the basis of examination and/or and manner stated.		occurred at the time,		
	With To T	Σ	29b. Signature and title of certifier	y fee	29c. License number	-0	29d. Date signed (Month	
	\.		20 Name and officer of	ploted copies of death (the scale)	0 W4X65	y / 1.11-	JANUARY	16 2000
	Ų		30. Name and address of person who com	Ab M.D	0 W4265 a. Print) 5601 LOCI BAKTIMOLE	MARY	LAND TIT	79
	St	ate	31. Date filed (Month, Day, Year)	32 Flogistrar's Signature		1		
	Regist	rar	JAN 1 7 2000	Broken St. Fol				

ARTICE ALSTON Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Unpend item#10e,23a,PII,27,penME,0352,2/22/06 TI
State of Maryland / Department of Health and Mental Hygiege 06-00304 RJ 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Month **Physician** 12, January 2006 Tice 2:42 p. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore County Northwest Regional Hospital Randallstown If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months 1 XM 2 ☐ F 35 158-46-7276 Director New Jersey Usual Residence of Deceden death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show if Heath and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28a-f shov other traumatic event, it a Musical Exaction must be retified at 13a 1 ☐ Yes 2 No Funeral Director andallstow 10g. Citizen of What Country? U.S.A 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be fited within 72 hours after 1 ☐ Yes 2 ▼No If Yes, Give / Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😿 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DONOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) orvection 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Sumame) Be or Town, State, Zip Code), 2/13 Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ri Bra 8608 datsto a Dorah / . Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Twn, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If It any injury or conce. Jan 20 2004 Newark 21. Signature of Funeral Service License Ballo ullah 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Acute Subarchnoid Henorrhage /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consugnence of) Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed ettending physicien and for use es the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Cher (specify) ed by the e 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertensive cardiovascular disease 1 ☐ Yes 2 ☐ No 3 Probably 4 Nunknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ▼Yes 2□ No 24a. Was an autopsy performed? 1X Yes 2□ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 ☐ No Certification: To 1 Inpatient 2 XER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical January 13, 2006 29b. Signature and title of certifier 29c. License number OCME my

Registrar
DHMH 17 Rev 1/2001

State

Baltimore, Maryland 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street

32. Registrar's Signature

-T

31. Date filed (Month, Pay, Year) 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** JANUARY 12,2006 5:05 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center Baltimore Towson 7. Age (In yrs. last birthday) II Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, 9. Birthplace (State or Foreign Country) Social Security Number **Funeral** Days 1 ☐ M 2 M F 13-90-744 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10a. Sta 10d. Inside City Limits or 28a-1 show or other traumatic event, the Medical Exercicer must be notified at 1 Yes 2 No Completed by Funeral Director to Move 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4616 451 238 20ad Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No II Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Bla Specify: 3 Widowed 4 Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other than (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last, Mother's Name (First, Middle, Be Pages 1 and 2 should be 1 ment of Health and Mental I ent: If item 27 is marked o Informant's Name/Relationship (Ty 19b. Mailing Address (Street Numb yral Route Number, City or Town, State, Zip Code) lema 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location 1 🗆 Burial 2 Cremation 3 Removal from State Department of Importent: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) reen 21. Signature Funeral Service 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ADRTIC DISSECTION ONE DAY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Records, P.O. Box 68760. Be Completed by Physician/Medical After this certificate has been signed by the attending physituneral director, page 2 should be detached for use as the t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy lindings available prior to completion of cause of death?
1 ☐ Yes 24 No 24a. Was an Division of Vital 1 Yes 20 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 2 ER/Outpatient Certification: To 1 🗌 Yes 21 No 1 Inpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai completely (Check only one) and manner stated To the 29b. Signature and the ol certifier 29c. License number 29d. Date signed (Month, Day, Year) anna D 62312 January 12, 2006

Registrar

DHMH 17 Rev 1/2001

State

ORIGINAL

OSLER DRIVE TOWSON MARYLAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7601

32. Registrar's Signature

SCOTT BRANNAN M. D

31. Date liled (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Leonard M. Atkinson January 12, 2006 6:45 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Manor Care Falls Road N/ABaltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Min 1 ☑ M 2 🗆 F 87 Yrs. 218-05-4840 1918 Marvland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location XIX Yes 2 No N/A Baltimore Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21211 USA 3434 Hickory Avenue 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 KM es 2 □ No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: white 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Proctor & Gamble Factory Worker 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ida Mae Redmon Leonard Eugene Atkinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timonium, Laura G. Ruby Daughter 220 Cinder Road Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XDBurial 2 ☐ Cremation 3 ☐ Removal from State Good Shepherd Cemetery 1/16/06 Ellicott City, MD ⁴ 4 ☐ Donation 5 Other (Specify) Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland shock, or heart failure. List only one cause in each line. 21. Signature of Funeral Service Ligense 22. Name and Address of Facility 21211 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) acopon Due to (or as a condequence of) anno Due to (or as a consequence of): Decident scoo vasi Due to (or as a consequence of): sen 23c. If yes, outcome of pregnancy 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 Fetal death Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Donknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 2. No 1 ☐ Yes

Physician /Medical Examiner

signed by the attending physicien and d be deteched for use as the buriat-transit

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this certificate has

After this c funeral dire

Hospital or Attending Physician:

within 24 hours after death. To the Funeral Director: A

certificate be executed

Division of Vital Records, P.O. Box 68760

Examine

Physician/Medical

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Completed

Be

Certification; To

1 Yes

3 Suicide

4 Homicide

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any july or other traumatic event 20x8.

Physician

/Medical

Examiner

Funeral

Director

e filed within 72 hours after death with the Maryland at Hyglene.
other than "natural", or flems 23s or 28s-f show

Baltimore, Maryland 21215-0036

r than "natural", or items 23a or 28a-f show the Medical Exandrar must be notified at

Director

Funeral

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Completed

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28d. Describe how injury occurred

25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

28a. Date of fnjury (Month, Day Year) 27. Manne of Death 1 Natural 5 Pending investigation 2 ☐ Accident

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Ente 308

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and title of certifier

29c. License number MD

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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A (HAS(M))

82(N. ELITAW ST

31. Date filed (Month, Day, Year)

32. Registrar's Signature market

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Registrar Amend Item #1 Per Phy G851 1977/06 Jil Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 1:25 AM canore Fleanor Margaret Albaugh January 10,2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Hopkins Bayview Medical Center Bastimore II Under 1 Year II Under 24 Hrs. Date of Birth (Month, Day, Year) 8/30/1925 9. Birthplace (State of Foreign Country) Illinois 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M 2₩ F Days Hours 80 355-14-1774 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or iteme 23a or 28a-f ahow The Medical Example must be notified at MD Director Baltimore 1 Yes 2X No Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 100 Eastern Blvd. permit. Pages 1 and 2 should be filed within 72 hours after death v. Depertment of Health and Mental Hygiene importent: if Item 27 is marked other than "natural; or Iteme 23a any hijury or other treumatic event, Ita Mudical Exe. It was reserved once. 21221 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 Yes 2 No ģ Specify: 3 ☐Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cashier Grocery Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) August Bjorklund Margaret Carr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Albaugh/Son 6 Treadway Ct. Baltimore, Maryland 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 5 Other (Specify) Gardens of Faith 1/13/06 Baltimore, Maryland Fur ral Service Licensee 22. Name and Address of Facility $Miller-Dippel\ Funeral\ Home\ Inc.$ 6415 Belair Road Baltimore, Maryland 21206 2' a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, of he in failure. List only one cause on each line. Approximate Interval Between Onset and Death Im. ed ate Ca. s. (Final dis an e or con fron resulting in death) Physician Cancer Metastatic Liver Metastasis with /Medical Due to (or as a consequence of): Examiner Hitery Due to (or as a consuluence ol) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. Examine The law requires that the death certificate be executed burial-transit attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 25 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? certificate 2 X No 1 Tes 280 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifice 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Hospital: Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No М 2 Accident illed in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number RES 000 completed cause of death (Item 23a) (Type, Print) 10,2006 ueA. and address of person who Jaura A. Hanyok 31. Date liled (Month, Day, Year) 4940 Eastern Bartimone, MD mD; 32. Registrar's Signature State JAN 1 7 2006 Registrar

		T = For State Registrar	State	of Maryla		artment of tificate o			-	giene Reg. No	ZIIII	00692
		1. Decedent's Name (First, Midd	lle, Last)						2. Date of De Month	ath Da	y Year	3. Time of Death
Physici /Medio		James			Bobbi	tt			1	3	2006	10:15a M
Examir		4a. Facility Name (If not institution Joseph Richy		umber)		4b. City, Town	, or Location Baltin			40	. County of Deat NA	h
Funeral		Social Security Number	6. Sex	7. Age (In yrs	s. last birthday)	If Under 1 Yea	ar If Unde	er 24 Hrs.	8. Date of Bir	th	9. Birti	hplace (State or Foreign
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pu k		Usual Residence of Decedent 10a, State 10b, Count	<i>u</i>	100.0	ity. Town or Lo	cation						10d. Inside City Limits
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2019		/ dreng	the			March F			1101	. E.	North A	ve.
		23a Part1. Enter the disease, shock, or heart failure. Lis	or complications that t only one cause or	caused the dea each line.	ath. Do not ent	er the mode of d	lying, such a	is cardiac o	or respiratory a	rrest,		Approximate Interval Between Onset and Death
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or Atte	Certification:	3 ☐ Suicide 6 ☐ Could deter	mined 288. Pla	ce of Injury - At I		eet, factory, offic	æ	2	28f. Location (: City or Tox			ral Route Number,
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To the Hospitel or Attending Physicien: The law requires that the death certification 24 hours eller death. To the Funeral Director: After this certificate hes been signed by the eltending completely filled in by the funeral director, page 2 should be detached for use es	Me	29b. Signature and title of certif				29c. Lice	nse number	r		29d. Da	te signed (Month	n, Day, Year)
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1		30. Name and address of perso	n who completed ca	use of death (Ite		Print)						
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			1 - For State Registrar	State of M	Marylan		artmen tificate				lental Hy	/giene Reg. No.) ()	5 (0693	
	Physici	an	Decedent's Name (First, Middle, Las MA V.			-					2. Date of De	eath Day		Year	3. Time of Death	
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П	Examin	er	4a. Facility Name (If not institution, give GENESIS ELDERCAR		r)				Location of			4c. (County o		undel	
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	28a-1	ect	Maryland Anne Ar	undel	P	asaden	10f. Zip	Code				10g. Citiz	en of W	hat Coun	- 53	_
	3a or	<u>a</u>	1890 Cedar Road				1011 2.0		122				S.A	nat Cour	u y :	
	death ms 2	Funeral Director	11. Marital Status	12. Was Deceder	t Ever in U.	S. 13. \	Was Deced	ent of Hi	spanic Ori	gin? (Sp	ecify Yes or No Rican, etc.)		4. Race		an Indian,	
9	or Ite	F	1 ☐ Never Married 2 ☐ Married	Armed Forces 1 ☐ Yes 2 ☐ If Yes, Give	No		ires,spec 1 ⊟ Yes 2		Specify:	i, Puerto	rican, etc.)	i		, White, Whi		
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b	should be filed within and Mental Hygiene.	BeC	17. Father's Name (First, Middle, Last)		•				18. Mothe	r's Name	(First, Middle	, Maiden S	umame)		
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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28s-f ahow any figury or other traumatic event, the Medical Examinist be notified at once.		*4 □Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		010		. Name and				-00	GTell	Duri	iie,	Maryland	_
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	/Medical Examiner		resulting in death)	Due to (or a	s a consequ										1 10 20.	>_
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	the at	/sici	1 ☐ Yes 2. No 9 ☐ Unknown	4□Pregnant 9□Unknown	at time of de		Other (spe						Monti	n	Day Year	
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_	spita nours neral		29a. Certifying Phy	/sician: To the bes	t of my knov	viedge, death	occurred a	it the time	e, date and	d place, a	and due to the	cause(s) a	nd manr	ner as sta	ited.	_
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: Atter this certificate ha completely tilled in by the funeral director, page	edical	(Check only 2 Medical Examone)	iner: On the basis and manner s	of examinati	ion and/or inv	estigation,	іп ту ор	inion, deat	h occurre	ed at the time,	date and p	lace, an	d due to	the cause(s)	
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(1		30. Name and address of person who o			61	Print)	110	0 -	5 01	La	710-		4 -	2006	
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	Sta Registr		JAN 1 7 2006	A second	A. S.	Cornell	3						(

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#17,18 perFH (851,1/27/06 TT) State of Maryland Department of Health and Mental Hygiene 0 6 1 - For Stata Registrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 13 13 EDGAR AUGUSTUS BRODHEAD III January 2006 11:00 PM 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Holy Cross Rehab. & Nursing Center Burtonsville Montgomery 8. Date of Birth (Month, Day, Year) Jan • 6, 15 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours Min 100 M 2□ F 177-01-8926 88 1918 Pennsylvania Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Prince George's 1 Yes 2 No MD Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9272 Cherry Lane, Unit 73 20708 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Printer U.S. Government 17. Father's Name (First, Middle, Last) L.A. Brodhead, JR. 18. Mother's Name (First, Middle, Maiden Sumame)
COTA LENA KETT Perry Cravner Anno Korr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leigh Brodhead/Wife 9272 Cherry Lane, Unit 73 Laurel, MD 20708 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location · City or Town, State 1 ☐ Burial 2 🗡 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crem. 1/16/2006 Odenton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral HOme, P.A. (M01103 313 Talbott Avenue, Laurel, MD anuceon Approximate Interval Between Onset and Death 23a. Part 1. En let the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Month than Immediate Cause (Final Lung Carcinoma disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 23e. Did tobacco use contribute to the cause of death? Congestive Cardiomyopathy Ventricular 1 XYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Arrythmias 24a. Was an autopsy performed? 1 Yes 1 Yes 2 🔯 No 2X No

Physician /Medical Examiner The law requires that the death certificate be executed

Physician

/Medical

Examiner

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Director

Itam 27 is marked other than "natural", or Itame 23s or 28s-1 show other traumatic event, the Madical Examinar must be multiled at

permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or income eny injury or other traumatic event.

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nding physician and use as the burial-transit signed by the attending I be detached for use as cate has been si certificate tor: After this certific the funeral director,

Division of Vital Records, P.O. Box 68760.

o the Hospital or Attending Physician:

er death.

within 24 hours after de To the Funeral Directo completely filled in by th

Physician/Medical Completed by Be Certification:

Examiner

23b. Was decedent pregnant in the past 12 months? 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death

28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Xatural

2 Accident

3 Suicide

4 Thomicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

20707

29b. Signature and title of certifier

29c. License number D22755

29d. Date signed (Month, Day, Year) January 14, 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Christine DeLima, MD 7350 Van Dusen Rd, Laurel, MD

31. Date filed (Month, Day, Year)

JAN 1 7 2006



7

State

Registrar

2 ER/Outpatient 3 DOA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Gilbert Bruce, Jr. Month 2006 23:01 PM William January 12 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat BALTTMORE If Under 1 Year If Under 24 Hrs. MIA HEALTHCARE AGNES 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 219.12.8895 Days Hours 1**X**M 2□ F 81 Yrs. MD 08.05.1924 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD Baltimore 1 XYes 2 □ No 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 2302 Monticello Road USA 21216 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Mayes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Marned 1 ☐ Yes 2 No Specify. Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ntary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Dperator rane Bethlehem Steel NIA 18. Mother's Name (First, Middle, Maiden Sumame) William G. Bruce, Sr. Estelle Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WIP Baltimore MD 21216 Lillie Mae Brule 2302 Monticello Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 01.19.06 Oning Mills, MD Garnson Forest 4 □ Donation 5 □ Other (Specify) 21. Sign tu of Funeral Service Licensee 22. Name and Address of Facility Compassion Funeral Services 119-121 5. Stricker street Baltimore MD 21223 MARIO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Embolism days ulmonary Due to (or as a consequence of) Sequentially list conditions, it any, leading to infine under cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of). IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 2 X No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide

burial-transit 68760 signed by the ettending physicien d be detached for use as the buria Physician/Medical Box (o. Records. δ certificete has been s irector, page 2 should Medical Certification: To Be Completed Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, ŏ Division

Physician

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Funeral

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State Registrar

Medical Doctor 29c. License number 9509

ACCRTITYING Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

January, 12, 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900

Caton Ave Baltimore, MD, 21229

desimenci 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

32. Poistrar's Signature

			1 - State Registrar	State of Maryland	Department of H		6	4000	00696
	Physici	an	Decedent's Name (First, Middle, Las	D	- Cortinoate or	2	. Date of Death Month	Day Year	3. Time of Death
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	Funeral Director	2	5. Social Security Number 6. So	yorial Hog	oital Ba	Hours Min.		9. Bin	thplace (State or Foreign punity)
	ryland how		10a. State 10b. County	10c. City, T	own or Location				10d. Inside City Limits
	he Ma 28a-f	Director	MD	Bal	timore				1 XYes 2 No
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	7		30. Name and address of person who Swami Paade	completed cause of death (Item 23		hospital	Prolitica	APTO M	0 21218
3	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature		riuspical	<u> </u>	nuse Fil	1/4/4/8
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	Examir		4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Death		c. County of	
-47			UNION MEMORIAI	L HOSPITA	AL	BA	LTIMORE			
	Funeral		Social Security Number 6. Se		(In yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) g	Birthplace (State or Foreign Country)
				M 2□F	79 Yrs.			DEC. 2	8,1926	DELAWARE
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	eho	5	MD		BALTIMO					1 📑 Yes 2 🗆 No
	the A	ect	10e, Street and Number		DALITMO	10f. Zip Code		14	2 27 /447	71
	ath with	Funeral Director		STREET		21:	211		0g. Citizen of Wh	•
215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other then "natural", or iteme 23a or 28a-f show any Injury or other traumatic event, ite Medical Examinal matter matters and lifed.	þ	11. Marital Status 1 □XNever Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Endrmed Forces? 1 ☐ Yes 2 ☐ Not If Yes, Give Year or Dates:	ver in U.S.	8. Was Decedent of H If Yes, specify Cub 1 Yes 2 No	Hispanic Origin? (Spe an, Mexican, Puerto Specify:	ecrly Yes or No- Rican, etc.)		American Indian, White, etc. WHITE
S.	72 h 'natu	Completed	15. Decedent's Edu (Specify only highest grad		16a. Dec	edent's Usual Occup	oation during most of worki	na 1	16b. Kind of Busin	ness/industry
2	nithin 100	du	Elementary/Secondary (0-12)	College (1-4or 5+	3		during most of worki d)			
7	ed w ygier ver th	Co		4	F	LAYWRIG			THEATE	R
D D	be fil tal H d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, M	Maiden Surname)	
<u>Ş</u>	Men Men arke	ို	JAMES I. BOYCE				CAROLY	N LONG		
Maryland	2 sh and and ls m		19a. Informant's Name/Relationship (T)	_			and Number or Rura			
	and ealth m 27		BILL BOYCE	nephew			TIVERTO			
altimore,	Pages 1 ment of H ant: If its ury or ot		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		20b. Place of Dis cemetery, cr GREEN	ematory or other pla	^{ce)} 1/16/		20c. Location - Ci	
Bait	permit. Departimport any Inj		21. Signature of Funeral Service Licens	ee			SS of Facility HE			S & SONS CO 21111
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only o Immediate Cause (Final	ications that caused t ne cause or thine	he death. Do not e					Approximate Interval Between
1	Pnysician /Medical		disease or condition resulting in death)	37712	150AN	mia				days
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Monre	consequence of):	uctive p	ulmonar	y Du	sease	years
8760,	cate be executed physicien and the burial-transit	dical Exar	that initiated events resulting in death) Last	Due to (or as a	consequence of);					
9		led								
O. Box	es that the death certifi igned by the ettending be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	☐Ectopic pregnancy ☐ Other (specify) _	<i>y</i>		23d. Date of Month	
ds, P	The law requires that the tite has been signed by the bage 2 should be detache		Part II. Other significant conditions co	ntributing to death but	not resulting in the	underlying cause giv	ren in Part I.	/		ute to the cause of death?
င်္ဂ	w requir been si should I	lete						24a. Was an		
Vitai Records,		Completed						autopsy	prio dea	re autopsy findings available r to completion of cause of th? Yes 2 No
\ <u>\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\</u>	ysiclan: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	fospital:	/	100	26. Place of Death	Check only one	1	
5	Phys this al dir	은	1 163 2 2 3 140	1 Linpatient			4 Nursing Hor		nce 6 Other	(Specify)
<u>_</u>	ding Ph h. After th funeral	lon:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time Injury	Wor		28d. Describe how	w injury occurred	
SIC	tend leath tor: /	cat	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 No			
Division of	tal or Attendin s efter death. al Director; Af ad in by the fur	Certification:	4 Homicide determined	28e. Place of Injury building, etc.	y - At home, farm, s (Specify)	street, factory, office	2	28f. Location (Str. City or Town,	eet and Number (State)	or Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours efter death. To the Funeral Director: Atter this certifica completely filled in by the funeral director, is	Medical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of ner: On the basis of e and manner state	xamination and/or	ath occurred at the tir investigation, in my o	me, date and place, a pinion, death occurre	and due to the cared at the time, da	use(s) and manne te and place, and	er as stated. I due to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	I Wes	lson.	29c. Licens	e number 054787	29		Month, Day, Year)
	10		30. Name and addess of person who co	pleted cause of dea	oth (Item 23a) ype	We MARI	al Hos	soute 1	Bal+	amaro Min
	Sta	te	31. Date filed (Month, Day, Year)	32. Panistrar	s Signature	1 0.		Prior	Juli	עיין אינויוו
	Registr	ar	JAN 1 - 7 20	06	w X A	bork				
DH	MH 17 Rev 1/2	001	ONIVI 1 44	4						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieges

			1 - State Registrar		,	Certificate	of Deal	th	R.	g. No.	6	00690
	Physici	an.	1. Decedent's Name (First, Midd					1	2. Date of Deat	th Day	Year	3. Time of Death
	/Medic			DINE DORIS QU					Januar	y 14,	2006	12:10 A ^M
1	Examin	er	4a. Facility Name (If not institution				wn, or Location			4c. County		
			EMERALD EST. 5. Social Security Number		je (In yrs. last birt		imore		3. Date of Birth		N/A	place (State or Foreign
	Funeral Director		215-10-6650 Usual Residence of Decedent	1 M 2 F			Days Hour	rs Min	Month, Day, Aug 31,	Year)	Cou	place (State or Foreign ntry) PEXAS
	ehow		10a. State 10b. Count	у	10c. City, Town	or Location						10d. Inside City Limits
	Mar a-f	tor	Maryland	N/A	Bal1	imore Ci	.ty					1 X Yes 2 □ No
	ith the	Director	10e. Street and Number			10f. Zip C	ode		1	0g. Citizen of	What Cou	ntry?
	ath w	rai	3855 Greenspr	ing Avenue			21211			US	SA	
	er de	Funeral	11. Marital Status	12. Was Decedent Armed Forces)	13. Was Deceder	nt of Hispanic Cuban, Mexi	Origin? (Specican, Puerto R	rfy Yes or No- ican, etc.)		e - Ameri ck, White,	can Indian, , etc.
21215-0036	filed within 72 hours after death with the Maryland thygiene. ther then "natural", or Items 23e or 28e-f ehow int, ite Medical Exeminar must be notilied at	by	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	If Yes, Give A	No .	1 ☐ Yes 25	No Spec	cify:		Specif	v: Wh	nite
15	be filed within 72 ho ital Hygiene. id other then "natur event, ine Modical	Completed	15. Decede (Specify only high	nt's Education est grade completed)	16a.	Decedent's Usual (Give kind of work life. DO NOT use	done during n	nost of working	7	16b, Kind of B	usiness/Ir	ndustry
12	2 should be filed within n and Mental Hygiene. 1 le marked other then "reumatic event, the Max	m.	Elementary/Secondary (0-12)	College (1-4or	5+)	Sales A	•			Rea1	Feta	ıto.
	Hygir Hygir other		12th 17. Father's Name (First, Middle	. Last)		bares 1		other's Name (First, Middle, I	Maiden Suman		ite
Maryland	id be entai ked c	To Be	Clifford		Quinta1		17	ena		Bi (gers	
ary	shound M mar	-	19a. Informant's Name/Relation	ship (Type, Print)		Mailing Address (Route Number			
	ges 1 and 2 should t of Health and Mer If Item 27 le marke or other traumatic		John Stephen 20a. Method of Disposition	Bentz (Son)	20b. Place of	Dalton Disposition (Name	Street	, Rumfo	ord, RI	02916		own, State
<u>o</u> L	ages ent of nt: If I		1 ☐ Burial 2 🂢 Cremation 4 ☐ Donation 5 ☐ Other (r, crematory or oth Ridge Cei		1/16			-	
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 It eny injury or other tra ance.		21. Signatu of Funeral Service	Licenstee		22. Name and	Address of Fa	cility				
			Martin D. 23a. Part1. Enter the disease, or heart failure. Lie	LaWSON or complications that cause	d the death. Do n	6500 Yo	rk Roa	d, Balt	imore,	<u>Maryĺa</u>	ind 2	1212 Approximate
	Dhusisian		shock, or heart failure. Lis Immediate Cause (Final	tomy one oddoo on oddin	-		, g		,	,		Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)		a consequence of							· · · · · · · · · · · · · · · · · · ·
Н	Examiner			BONE		TASAS	SES					
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	0	a consequence of							
	ortificate be executed ing physicien and e as the burial-transit	Examiner	that initiated events	1. BRE	AST O	CANCE	ER					
oʻ	e exe ien a urial-l		resulting in death) Last	Due to (or as	a consequence of	of):						
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	entific ling p	Mec	IF FEMALE:							1		
O. Box	The law requires that the death certificate be executed ase has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death	3 ☐ Ectopic prec 5 ☐ Other (spec					te of deliventh	ery Day Year
П,	res that igned b be deta	y P	Part II. Other significant condit	tions contributing to death t	out not resulting in	the underlying cau	ise given in Pa	art I.	23e. Did tol	oacco use con	ribute to t	the cause of death?
rds	quires n sign	Q D	CONGESTIN	UE ITEAR	THA	ILURE			1 □ Ye	s 2 No	3 🗆 Pro	bably 4 Unknown
of Vital Records,	aw requir s been si s should	Completed by							24a. Was a	n 24b.	Were auto	opsy findings available
Re	The it	E							autops	tied?	death?	mpletion of cause of 2□ No
ital	ten: rtifice	a)	25. Was case referred to medic	al			26. PI	lace of Death	1 Yes :	7	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2 140
T V	Physicien: this certifice ral director, p	ToB	examiner? 1 ☐ Yes → No	Hospital:	ent 2 ER/Out	patient 3 DOA	Other		e 5 🗆 Reside		er (Speci	MALF
0 4	ng Pl	ä	27. Manner of Death ND Natural 5 ☐ Pend	28a. Date of Inj	ury 28b. T	ime of 280	. Injury at Work?	28	d. Describe ho	w injury occur	red	
sio	eath. or: A	catl		tigation		М	1 ☐ Yes 2	No				
Division	or Ati	Certification:		mined 286. Place of in	jury - At home, fai tc. <i>(Specify)</i>	m, street, factory,	office	28	If. Location (SI City or Town	reet and Numb n, State)	er or Rur	al Route Number.
	pitel urs a arsi D		20. 0. eff Mo. et									
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funers! Director: After this certificate has completely filled in by the funeral director, page 2.	edical	29a. Certifier 1 Certify (Check only one)	ing Physician: To the best of Examiner: On the basis of and manner s	of examination and	, death occurred at dor investigation, is	the time, date n my opinion,	e and place, and death occurred	d due to the cand at the time, d	ause(s) and ma ate and place,	anner as s and due t	stated. to the cause(s)
	To t To t	Σ	29b. Signature and title of certif	ier	^ -	29¢.	License numb	er	2	9d. Date signe	d (Month,	Dey, Year)
			Kendas	2e Mai	elle		かりか	043		01/14	+/2	2006
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5	Sta Registi		31. Date filed (Month, Day, Yea JAN 1	7 2006 327Regist	rar's Signature	Grade						

		- State Registrar Amend Item	State of M #18 Per		_					Я	leg. No.	JUb	005	99
Physicia		Donald D	rwin Bak	or						2. Date of Dea Month	Day	Year	3. Time of	
/Medic Examin		4a. Facility Name (If not institution, give				4b. City,	Town, or	Location o		January	_	2006 ounty of Deatl	9:52	A M
LAdimii	101	Good Samaritan	Hospita	1				re Ci				N/A	-	
Funeral		5. Social Security Number 6. Se			last birthday) Yrs.			If Under 2	24 Hrs.	8. Date of Birth April Day	Yoar) 1	9. Birth	hplace (State o	or Foreig
Director		Usual Residence of Decedent		45	rrs.					April 1	.0, 1	aon Mi	chigan	
ytarıcı Now		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside C	ity Limits
Mail Sala	ctor	Md. N/A				Bal	timo	re Ci	ty				1 🔥 Yes	2 🗆 No
72 hours aller death with the Maryland natural; or Itema 23a or 28a-1 ehow dical Exercitivat to notified at	Director	10e. Street and Number				10f. Zip	Code			1	10g. Citize	n of What Co	untry?	
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Heme Heme	Funeral		12. Was Deceden Armed Forces 1X Yes 2	?	I.S. 13. V	Vas Deced Yes, spec	dent of Hi orfy Cuba	spanic Orig n, Mexican	gin? (Spec , Puerto R	cify Yes or No- lican, etc.)	14	. Race - Ame Black, White		
natural, or iteme 23s or 28s-1 ehow	by F	1 Never Married 2 Married 3 Widowed 4 XDivorced	If Yes, Give Year or Oates:		1	☐ Yes	2XX No	Specify:			S	pecify.	White	
atura Ical		15. Decedent's Edu	cation		16a. Deced	lent's Usua	al Occupa	ation			16b. Kind	of Business/I		
then "r	ald u	(Specify only highest grad	College (1-4or	5+)	life. L	OO NOT us	se retired,	luring most)	of working	9				
tal Hygiene. d other then "natu event, it a Medical	Completed		2			Engin	eer						Militar	, À
	Be	17. Father's Name (First, Middle, Last)						18. Mothe		(First, Middle,				
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n 27 ie m		Ms. Nancy M. Revil		nion						Route Number imore,				
구들등		20a. Method of Disposition	re, compa	20b. I	Place of Dispos	sition (Nan	ne of	-	Daile	_		tion - City or		
0 = 5		1 ☐ Burial 2 X☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		9	cemetery, cren Itop Si	-			1/17	- 11		n, Mary		
HE TO BE		21. Signature of Funeral Service Licens		2 /				s of Facility		ck Tows				Inc
Pep any eny		muchael	Buch	1		105	O Yo	rk Ro		Towson,				1110
		23a. Part1. Enter the disease, or composhock, or heart failure. List only o	lications that caus	d the deal	th. Do not ente								Approximat Interval Bet	te
ysician		Immediate Cause (Final disease or condition			ricul		T	ach	u en	ndla			Onset and I	Death
Medical		resulting in death)	Due to (or a				/3		٠.	14			10 171	IIN
aminer		Sequentially list conditions,	b	lat	ied	Ca	noli	o m	10 No	a of him			5 4	Land S
sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consec	quence of):								•	
sicien and burial-transit	хап	that initiated events resulting in death) Last	c Due to (or a	s a consec	uence of):									
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attending p for use as	Physician/Me	230. Was decedent pregnant	23c. If yes, outcom 1 ☐ Live birth			Catonia na	25555				23	d. Date of deli	very	
ed for	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a			Ectopic pro Other (sp.						Month	Day *	Year
by the	Phy	9 Unknown												
pe de	by	Part II. Other significant conditions co	ntnbuting to death	but not res	sulting in the ur	nderlying ca	ause give	n in Part I.					the cause of d	
been si should b	sted									1 4	es 2 🗆	No 3∏Pro	obably 4 Ex	Unknow
2 5	Completed									24a. Was a autops	sy	prior to c	topsy findings completion of c	available ause of
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After funer	ţ	1 Natural 5 Pending 2 Accident investigation	28a. Date of In (Month, D	ay Year)	Injury	м	8c. Injury Work	?` ∕es 2.⊟N		od. Describe ric	ow injury (occurred		
octor: A	Certification:	3 Suicide 6 Could not be	28e. Place of Ir	njury - At h	ome, farm, stre					3f. Location (Si	treet and i	Vumber or Ru	ral Route Num	nber.
d in	Sert	4 Homicide	building, e	etc. (Speci	fy)	,				City or Town				
within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical (29a. Certifying Phy (Check only one) 2 Medical Exami	sician: To the besiner: On the basis and manners	or examina	owledge, death ation and/or inv	occurred estigation,	at the tim	e, date and pinion, deat	d place, ar	nd due to the ca d at the time, d	ause(s) ar	nd manner as lace, and due	stated. to the cause(s	5)
To tr comp	ž	29b. Signature and title of certifier)				License			2	9d. Date :	signed (Month	, Day, Year)	
) Watel >	manne	~	1.D.		I	152	0 (6	1/	14/	2006	
la la												1 /		
10		30. Name and address of person who of	_	death (Iter	m 23a) (Type,	Print)	₫. ╡	+ 65	5, B	e lett m	~osle	MD	2/2/	8

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 13 Alberta Craqway 2006 0740a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3132 Harview Avenue Baltimore 5. Social Security Number ff Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea 5–14–24 Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 X F Davs Hours Min Yrs. 215-14-9311 Director 81 ۷a. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits , or Items 23a or 28a-f ehow the Medical Exemples must be notified at 1 X Yes 2 □ No Funeral Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3132 Harview Avenue 21234 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ZNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: 3 ☐ Widowed 4 X Divorced Black "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "ne any injury or other traumatic event, the Medic 2006. Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping 12th grade Varies 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Rov Cragway Minnie P. Megginson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jerilyn Roberts Daughter 1605 Bearpaw Lane, Hanover, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Arbutus Mem. Pk. 1-19-06 Arbutus Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Baltimore, Md. 21202 March F.H. East cely 1101 E. North Ave. 23 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finaf disease or condition resulting in death) Physician ORIONARY DISSASE 2003 /Medical Examiner HYPERTENSION 200 S. pentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetaf de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetaf death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) o. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by sete has been sign page 2 should be 1 ☐ Yes 2 ➡Ño 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2 No 1 Yes 2 No r: After this certifice e funeral director, p 25. Was case referred to medical examiner? Be 26. Pface of Death | Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 2 ER/Outpatient 3 DOA 27. Manper of Death 1 Natural Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending I Director: A 1 ☐ Yes 2 ☐ No death 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by within 24 hours after To the Funeral Direct 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D22652 13/06. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BND BALTIMORE MD 21239 Dr. S. SRINIVA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

		•	State of Maryland / Department / Department / Depart		lental Hygie	•	00701
Physic /Med Exam	lical	Decedent's Name (First, Middle, Last) Mary Etta Cook Aa. Facility Name (If not institution, give stru Gilchrist Center	eet and number)	4b. City, Town, or Location of Death	2. Date of Death Month January	Day Year 15, 2006 4c. County of Death Baltimo	3. Time of Death 8:32 A M
Funera Directo		210 02 0007	7. Age (In yrs. last birthday)	Months Days Hours Min.	8. Date of Birth (Month, Day, Y Feb. 16,	ear) 9. Birthp Cour 1935 Mar	place (State or Foreign http) LYLand
h the Maryland or 28e-f ehow	Irector	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimore 10e. Street and Number		Middle River	10g	J. Citizen of What Cour	1 Od. Inside City Limits 1 ☐ Yes 2 ☑ No
IIIU X IX I 3-0000 be filed within 72 hours after deeth with the Maryland tal Hygiene. Id other than "natural", or items 23a or 28e-f show avant. Its Maylial Examinar must be notilised at	by Funeral Director	12925 Loyola Road 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	. Was Decedent Ever in U.S. 13. Armed Forces? 1 Yes 2 No If Yes, Give	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	U.S.A. 14. Race - Americ Black, White, Specify: Whu	etc.
Mid y Idilia Z IZ I 2-0000 d 2 should be filed within 72 hours af th and Mental Hygiene. ?? Is marked other than "natural", or traumatic avant, the Modical Exami	Completed b	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12) 12th Grade	completed) (Give life.	odent's Usual Occupation a kind of work done during most of work DO NOT use retired) 2mbler	ing G	ib. Kind of Business/In Beneral Mot Janufacturi	tors
D 2 2 2 2	To Be C	17. Father's Name (First, Middle, Last) Albert Schmick		18. Mother's Nam Mangan	e (First, Middle, Ma		
			usband) 1292	ing Address (Street and Number or Rui 5 Loyola Road, Mid	dle River	L, MD 2122	20
permit. Pages 1 ar Depertment of Hea Important: If Itam any injury or othe		20a. Method of Disposition 1	Highview	matory of other place) Mem'l Gardens 1/1	9/2006 Fa		ryland
permit. Depentiment	ġ	21. Signature of Funeral Service Licensee	Kuneker	2. Name and Address of Facility Sch 9705 Eccain Rd., B	altimore,	MD 21236	S
Physicial /Medica Examine	1	23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sayuentally list conditions if any, leading to immediate cause. Enter Undertying Cause (Disease or injury		Lateral Sch			Approximate Interval Between Onset and Death
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uires thet the signed by the d be detached		Part II. Other significant conditions contr		underlying cause given in Part I.	23e. Did toba	cco use contribute to t	he cause of death?
ystcian: The law requires t ystcian: The law requires t is certificete has been signe director, page 2 should be o	Completed				24a. Was an autopsy performe	24b. Were auto	opsy findings available empletion of cause of
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To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Hornicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stre City or Town,	et and Number or Rur State)	al Route Number,
To the Hospitel or within 24 hours affe To the Funers! Dire completely filled in b	Medical	(Check only one)	cian: To the best of my knowledge, dea pr: On the basis of examination and/or in and manner stated.	th occured at the time, date and place, nvestigation, in my opinion, death occur	and due to me cau red at the time, date	se(s) and manner as se and place, and due to	itated. o the cause(s)
or With	Σ.	29b. Signature and title of certifier	Vailles	29c. License number 29c. Doc 43 29c. Print) 20c. Street/80		1. Date signed (Month,	Day, Year)
ク ^ツ '	State	30. Name and address of person who com Kendoll Rhaukne 31. Date filed (Month, Day, Year)	pleted cause of death (Item 23a) (Type MD/6601 N Ch 32. Registrar's Signature	accestreat/80	elto Mi	3120	4
Regi	strar	JAN 1 7 20	06 Pagues & A	Soul			

State of Maryland / Department of Health and Mental Hygiene For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Carlisle Clinton 12, Conollev. January 1:40 P M 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Home; 1434 Dellwood Avenue Baltimore N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours 215-28-5733 73 Yrs. Director 15, 1932 Aug. Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f ahow any injury or other traumatic avant, the Medical Evantment willbed at once. 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits N/A Completed by Funeral Director Maryland **Baltimore** XX Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1434 Dellwood Avenue 21211 USA 12. Was Decedent Ever in U.S. Armed Forces? MRYes 2 □ No If Yes, Give Year or Dates: Korea 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 Never Married 27 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify. 3 ☐ Widowed 4 ☐ Divorced white Korea 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Sheet Metal Mechanic Nurad, Inc. 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Earl Showers Conolley Edith Velma Kelbaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Conolley Wife 1434 Dellwood Avenue Baltimore, Maryland 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XX Burial 2 ☐ Cremation 3 ☐ Removal from State Lorraine Park Cemetery 1/17/06 * 4 □ Donation 5 □ Other (Specify) Woodlawn, Maryland 21. Sign y re Funeral Servic Licensee 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 21211 23a Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition resulting in death) Months Cancer una /Medical Due to (or as a consequence) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No performed? 1 🗌 Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 Z No 28a. Date of Injury (Month, Day Year) 27. Manner of eath 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending within 24 hours after death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00055035 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raum Blux Baltimor Hallarman 3900 Loch 31. Date liled (Month, Day, Year) 32. Pegistrar's Signature 2006 Registrar

			Please Type or Print in Black Indel State of Maryland / Departm 1- State Registrer Certifit		•	. 1 0 0 0 0 0 0 0 0 0 0	}
#	Physici /Medi	cal	1. Decedent's Name (First, Middle, Last) Ormond George Cunningham, Jr.		o Carl La Part	2000	th M
	Examir Funeral Director	ner		paltimore	_	Ac. County of Death Baltimore 9. Birthplace (State or For Country) 88 Maryland	'eign
	th the Maryland or 28a-f show e notified at	Olrector	Maryland Baltimore Catonsvil		10g. C	10d. Inside City Lir 1 ☐ Yes 2 ☐ Citizen of What Country?	
9003	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23a or 28a-1 show other than "natural", or items 23a or 28a-1 show event, ira Medical Eracidi at must be notified at	d by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed Spivorced 12. Was Decedent Ever in U.S. Armed Forces? 12. Was Decedent Ever in U.S. If Yes If Yes, Give Year or Dates: Vietnam	21228 Decedent of Hispanic Origin? (Specs, specify Cuban, Mexican, Puerto R	ofy Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc.	
and 21215-0036	be filed within tal Hygiene. Id other then "	Be Completed	(Give kind life. DO No. 12 th. 17. Father's Name (First, Middle, Last)	18. Mother's Name (US (First, Middle, Maide	en Sumame)	
nore, Maryland	fealth fealth om 27 thar tr	To	Nicole Svejda (Daughter) 6140 Va	n (Name of Da	Route Number, City Frederi ite 20c.	y or Town, State, Zip Code) Ck, MD 21701 Location - City or Town, State	
Baltimore,	permit. Pages: Department of h Important: If ite any injury or of		21. Signature of Funeral Service Licensee 22. Nat 1 21 2	whe and Address of FacilityBurr W. Old Libert	ier-Que y Rd. W	Sykesville, MD en Funeral Hom infield, MD 21	e
68760,	Physician /Medical Examiner per principle prin	dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infiltated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	1	respiratory arrest,	Approximate Interval Between Onset and Death	h
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J	To the Hospital or Attent within 24 hours after death To the Funeral Director; comple ely filled in by the	Medical Ce	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurrence on the basis of examination and/or investigation and manner stated.	curred at the time, date and place, an gation, in my opinion, death occurred	nd due to the caused d at the time, date a	(s) and manner as stated. and place, and due to the cause(s)	
	within To the Comp	W	29b. Signature and title of certifier Medical Doctor	29c. License number P 1 9 5 0 9	29d. C	Date signed (Month, Day, Year) Thurang 13 2006	
	- Sta Regist	ate rar	30. Name and added of person who completed cause of death (Item 23a) (Type, Print Masa Ozego Mencional Signature 17 2006 132 Registrar's Signature 14 17 2006 132 Registrar's Signature	Coton Ave, B	altimor	e, MD, 21229	

			110400	State of Maryland				Mental Hydi	ener o e	00701
		•	1 - For State Registrar	State of Maryland		tificate o		, ,	2006 g. No.	00/04
	Physici	20	1. Decedent's Name (First, Middle, Li	ast)				2. Date of Death Month	Day Year	3. Time of Death
1	/Medic	al	Denise Marie	Callaghan		4h Cit. Tour		Jan. 9,	2006	12:35 pm
	Examin	er	4a. Facility Name (If not institution, gi				n, or Location of De	eatn	4c. County of Dea	
	Funeral			Sex 7. Age (In yrs. la	st birthday)	Baltin If Under 1 Ye Months Da	ar If Under 24 H	Hrs. 8. Date of Birth (Month, Day,	Baltimo	thplace (State or Foreign
4	Director		199-16-4324 Usual Residence of Decedent	^{1□ M} ² X F 81	Yrs.	WOTENS DA	ys riours in	01-21-2		otland
	yland		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Ba-1 et	ctor	MD Baltin	ore Bal	timor	:e				1 ☐ Yes 2 No
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	within 72 hours after death with the Maryland ene. than "natural", or Itame 23a or 28a-f ehow the Mudical Examiner must be codified at	by Funeral	6401 N. Charl	es Street	S. 13. 1	Was Decedent	1 2 1 2 1 0 0	(Specify Yes or No-	US Arace - Am	erican Indian,
9	or ita	/ Fur	1 Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 (★No If Yes, Give		lfYes, specify 0 1 □ Yes 2 🔀 I	Cuban, Mexican, Pu	ierto Rican, etc.)	Diack, Will	te, etc.
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Maryland	be fill bd oth	Be	17. Father's Name (First, Middle, Las	t)				Name (First, Middle, M	aiden Surname)	
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	iges 1 and 2 should be filed within 72 hours after death with the Marylar It of Health and Mental Hygiene. If Itam 27 Is marked other than "natural", or Itams 23s or 28s-f show or other traumatic avant, the Madical Examiner must be collised at		Bernice Feili	nger, SSND	6401	N. Ch	arles S			MD 21212
ore	or oth		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3	☐ Removal from State	ace of Dispo metery, crei	sition (Name of matory or other	place)	Date 2	Oc. Location - City of	
Baltimore,	rtmer rtant rtant		4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice		lla M		dress of Facility	-13- 06	Glen Arm	, MD
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			23a. Part1. Enter the disease, or conshock, or heart failure. List only	y one cause on each line.		1	1 0		st,	Approximate Interval Between Onset and Death
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760	ate be executed hysician and the burial-transit	calE		d						
89 J	entifica ing ph e as th	Medi	IF FEMALE:							
Вох	attend for us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3[Ectopic pregna		•	23d. Date of de Month	l ivery Day Year
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s, D	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	by Physician/Med	Part II. Other significent conditions	contributing to death but not resu	lting in the u	nderlying cause	given in Part I.	23e. Did toba	acco use contribute t	o the cause of death?
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Vital Record	ificate or, pag	e Co	25. Was case referred to medical				OC Place of I	1 ☐ Yes 2	No 1□Ye	s 2 No
Ž	Physician: rthis certific ral director,	To B	examiner? 1 Tes 2 No	Hospital: 1 Inpatient 2 I	R/Outpatier	nt 3 DOA	Other	Death <i>(Check only</i> one g Home 5 \subseteq Resider		ocify)
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Division	Attending or death.	licat	2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not	be 390 Place of laiver, At he	me farm st		1 ☐ Yes 2 ☐ No	28f Location (Str	eet and Number or F	Iural Route Number
<u>≥</u>	s after al Dira	Certification:	4 Homicide determine	building, etc. (Specify)	oot, lactory, on		City or Town,	State)	arar riodio rumbor,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Diractor: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier 1 Certifying F (Check only one)	Physician: To the best of my know aminer: On the basis of examinat and manner stated.	vledge, deat ion and/or in	h occurred at the	e time, date and planty opinion, death of	ace, and due to the car ccurred at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
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	•		10-1	1 mearlin		w_{o_1}	sol brooking	8673	Mrs. 1/1	106
	/		30. Name and address of person wh				_	_		
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			1 - For State Registrar	State of Marylar		artment of rtificate o			-	giene (6 (0705
	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last	CORNIAS	5	4b. City, Town	or Location of		2. Date of Dea Month ANUAY	Day	Year 2006 of Death	3. Time of Death 09:20 AM
	Funeral Director		5. Social Security Number 6. Sec. 213–84–4114 15 Usual Residence of Decedent	1110 10000	last birthday) Yrs.	Balt If Under 1 Yea Months Day			8. Date of Birth (Month, Day 3/5/19	, Year) 60	Cour	olace (State or Foreign stry) yland
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9000	72 hours after death with the Maryland natural; or Itams 23a or 28a-f show deal Examilies from the Indiffed at	Þ	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes ②M No If Yes, Give Year or Dates:		Was Decedent o If Yes, specify Cu 1 ☐ Yes 2 ☐ XN			ify Yes or No- ican, etc.)		ce-Amend ck, White,	etc.
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Baltimore,	permit. Pages Department of I Important: If It any injury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 1 ☐ Donation 5 ☐ Other (Specify, 21. Sign ture of Fuheral Service License	Oa	klawn	2. Name and Add	1	1/11/0				Maryland eral Home
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Divis	in the second	O	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci	fy) 				City or Town	n, State)		Route Number,
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İ	27		30. Name and address of person who be Kimbeli TAY or -1		п 23a) (Туре,	Print) In Gre	ne St	reet	Balti	71-ye , 14	July.	ed 217.01
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		For State Registrar	State of Mar		artment of H rtificate of I			iene) 06	00	707
Physicia Physicia		1. Decedent's Name (First, Middle, Las	t)		-		2. Date of Deat Month	h	3. T	Time of Death
/Medic				ace Deare			January	13, 20	06 2:	:50 A M
Examin	er	4a. Facility Name (If not institution, give Riverview Nursing				Location of Death		4c. County of		
Funeral		5. Social Security Number 6. Se		(In yrs. last birthday	Essex	If Under 24 Hrs.	8. Date of Birth		imore (CO • 'State or Foreign
Director		217-18-5582	M 2□F 82	Yrs.	Months Days	Hours Min.	(Month, Day, Oct. 13		Maryla	
and w.		Usual Residence of Decedent 10a. State 10b. County		IOc. City, Town or L	ocation				10d. In:	side City Limits
Marylan -f show lied at	tor	Maryland N/.	Z		TD:	altimore_(74+**		13	K∐Yes 2∐No
ith the M or 28a-f	Director	10e. Street and Number			10f. Zip Code	arcamore (0g. Citizen of Wh	at Country?	
ath wi	rai	6321 Hudson Stre				21224		United :		
If it is in the Maryland flied within the Maryland Hygiene. Hygiene in Institutel, or Items 23a or 28a-f show ant, the Maryland Examiner must be notified at	by Funerai	11. Marital Status 1 □ Never Married 2∑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (Spe in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Ind White, etc.	
2 hour	ted t	15. Decedent's Ed	Year or Dates: Tucation	16a, Dece	edent's Usual Occup	ation		16b. Kind of Busi	Whit iness/Industry	
be filed within 72 ho ital Hygiene. Id other than "naturevent, Ital Musical	Completed	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5+	(Give	e kind of work done o DO NOT use retired	during most of worki f)	ng		,	
filed Hygie other		12 Years 17. Father's Name (First, Middle, Last)		Cu	stodian	18. Mother's Name		<u>Dentist</u> Maiden Surname,		5
yidalid 2 12 buld be filed with Mental Hygiene. arked other than atic event, Italy	To Be	Conrad Deares					Mary E.	Leamon		
2 should and Men Is marke		19a. Informant's Name/Relationship (7	**		ing Address (Street					
of and 2 should be filed within a 1 and 2 should be filed within the alth and maked before the firem 27 is marked other than other traumatic event, Its M.		Mrs. Georgianna 1 20a. Method of Disposition	Deares (Wil	20b. Place of Disp	21 Hudson			e, Mary 20c. Location - C		21224
Pages nent of h		¥ Burial 2 ☐ Cremation 3 ☐		cemetery, cre	amatory or other plac	(e)	11			
그 문원 중 .		*4 ☐ Donation 5 ☐ Other (Specify 21. Signature Funeral Service Licen		1 2	d Mem. Pai 22. Name a <u>n</u> d Addres	ss of Facility		Baltimo	•	aryland
Dermi Depa Impo any it		Megon (Henry		Duda-Ruck 7922 Wise				, Inc. 21222	,
		23a. Part1. Enter the disease, o comp shock, or head ailure. List only	plications that caused the cause of the cause of each line	ne death. Do not er	nter the mode of dyin	g, such as cardiac c	or respiratory arre	est,	Inter	roximate val Between
Pnysician /Medical		Immediate Cause Final disease or conmion resulting in death)	a (-)/3/	emeri	dance	nto.			Offse	et and Death
Examiner			Due to (or its a	consequence of):	N	0 -				
	ner	Sequentially list conditions, if any, beauty to find ediate cause. Enter Underlying Cause (Disease or injury	b. Dua to (or as a	consequence of):						
ficate be executed physician and sthe burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Perin	consequence of):	vacula	duce	ne			·
cate be ex physician the burial	ai E		^ .	Consequence oi).						
GO/ ifficate g phys	edicai		d							
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome or 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)	,		23d. Date Mont		Year
uires that uires that signed b	by	Part II. Other significant conditions of	ontributing to death but	not resulting in the	underlying cause giv	en in Part I.		pacco use contrib		use of death?
The law requires: The law requires: ate has been signings page 2 should be	Completed						24a. Was a autops perform	y pri ned? de	ere autopsy fir or to completion ath?	ndings available ion of cause of
VICAL ician: 1 certificat ector, p	Be	25. Was case referred to medical examiner?	Hospital:			26. Place of Death				
Physical direction	. To	1 Yes 2 No	1 ☐ Inpatien 28a. Date of Injury			4 Virursing Ho		ence 6 Other		
oding th: :: After	ation	1	(Month, Day	Year) Injury	Wor	k? Yes 2□No		winjary occurre		
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, farm, s (Specity)	treet, factory, office		28f. Location (St City or Town	reet and Number n, State)	or Rural Rout	te Number,
e Hospit: 24 hours e Funera etely fille	edicai C	29a. Certifier 1 Certifying Ph	ysician: To the best of niner: On the basis of and manner state	examination and/or i	ath occurred at the tir nvestigation, in my o	ne, date and place, pinion, death occurr	and due to the ca	ause(s) and mani ate and place, ar	ner as stated. Id due to the c	ause(s)
To the within To the complete	Me	29b. Signature and little of certifier			29c. Licens		2	9d. Date signed	Month, Day, 1	Year)
) ()	SERASTIF	n Toit	00	055171		01/1	4/06	
5+1		30. Name and address of person who	completed cause of de	ath (Item 23a) (Type	a, Print)	Mo	1			
Sta	ate	3023 Easter 31. Date filed (Month, Day, Year)	32. Registrar	's Signature	marc	110	タ/ えん	7		
Regist		JAN 1 7 200	S A Section	13 193						

State of Maryland / Department of Health and Mental Hygiene . No.

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Year

			Registrar					Cei	uncau	e or i	Jeam			Reg. No.			
	Physicia		Decedent's Name (First, Middle	e, Last)	Will:	iam	Lee	Der				•	2. Date of De Month January	Day	Year 2006	3. Time of 21:57	
	/Medio Examin		4a. Facility Name (If not institution	n. aive str	eet and nun	nber)			4b. City.	Town, or	Location	of Death			county of Death		
	Examin	er	Backriver Neck				11 Ro	1.	Essex				Baltimo				
	Funeral Director		5. Social Security Number 215-31-8182	6. Sex	M 2□F	7. Age (li 18	n yrs. last	birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da June 1	y, Year)	Co	nplace (State o untry) ryland	r Foreigi
	Maryland -f show	tor											10d. Inside Ci				
	th with the 23e or 28e	al Director	10e. Street and Number 3415 Wallford			1			10f. Zip	Code	212	222		-	izen of What Country? nited States		
21215-0036	be filed within 72 hours after deeth with the Maryland lal Hygiene. Id Hygiene and the matural, or Itame 23e or 28e-f show event, the Medical Exerciper must be notified at	by Funeral	11. Marital Status 13☑ Never Married 2☐ Marr 3 ☐ Widowed 4 ☐ Divorced	ried	Armed Forces? If Yes, specify (1 ☐ Yes, 2 ☐ No If Yes, Give Year or Dates: If Yes, 2 ☐ Yes 2 ☐ Yes					rify Cuba	an, Mexican, Puèrto Rican, etc.) Black			Black, White	e - American Indian, k, White, etc. White		
		Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12)	(Specify only highest grade completed) (Independent of the property of the pr					dent's Usua kind of wo DO NOT us	rk done d se retired	during mos I)		king		d of Business/I	,	
2		5	12 Years					The	ater	Tech	nicia	an		Ent	ertainr	ment ———	
Maryland	should be file and Mental Hy a marked oth umatic event	To Be (17. Father's Name (First, Middle, Last) Rickwood A. Der, Sr.										e (First, Middle a A. Mi		umame)		
	s 1 and 2 should if Heelth end Men Itam 27 Is marke other traumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number)							per, City or Town, State, Zip Code) bridge, Maryland 2161:			1613				
Baltimore,	Pages 1 and nent of Heelt int: If Item 2 iry or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		moval from S	State	ceme	itery, crei	sition (Name matory or o	ther plac			Date 5/2006		ation - City or 1	Town, State)
Balti	permit. Pages Depertment of h Important: If Its eny Injury or of		21. Signature of Funeral Service	Licensee	ė (N	ass	22 D	Name an	d Addres	s of Facilit	al F	Home of	Dunda	alk, In		
j	Physician		23a. Part. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	complica only one	ations that cause on ea	ach line.	death. D	o pot ent								Approximate Interval Bety Onset and D	veen
	/Medical Examiner	er	resulting in death) Sequentially list conditions.	b.			onsequenc	ce of									
Sequentially list conditions, any leading to infried at cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):																	

ician/Medicai Physi ۾ Completed Be 2 Certification:

burial-tran

attending p

ed by the

icate has been sig r. page 2 should b

this

After

within 24 hours after death To the Funeral Director: completely filled in by the

death.

USB

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) 9 Unknown

1 Inpatient

2 ER/Outpatient 3 DOA

28b. Time of

9:43

28e. Place of Injury - Al home, farm, street, factory, office building, elc. (Specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown

1 🗌 Yes 24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1 ▼Yes 2 □ No

1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Scene

28d. Describe how injury occurred driver in motor vehicle collision Location (Street and Number or Rural Route Number, City or Town, State) Back River Neck Refet Fendril Road Essex, Mc

Diffenduil Road 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

25. Was case referred to medical

1 Ty Yes 2 □ No

27. Manner of Death

1 Natural

2 Accident 3 Suicide

4 Homicide

29a. Certifier

29c. License number

28c. Injury al Work?

1 ☐ Yes 2 No

29d. Date signed (Month, Day, Year)

O.C.M.E.

January 12, 2006

ed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

5 Pending

investigation

6 Could not be determined

111 Penn Street, Baltimore, Maryland 21201

State Registrar

Medicai



			1- For State of Maryland	Department of Health and N Certificate of Death	lental Hygiene Reg. No 006 00709
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year Vear 0925 AM
	/Medic Examin	al	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Jan 12 2006 0925 AM 4c. County of Death
	Examili	eı	Howard Country General Hospita	l Columbia	Howard
Ι.	Funeral Director		5. Social Security Number 077-09-4735 Usual Residence of Decedent 5. Sex 7. Age (In yrs. last 92 92 92 92 92 92 92 9	Yrs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) NEW YORK
	yiand how		10a. State 10b. County 10c. City, T	own or Location	10d. Inside City Limits
	Ba-f s	ector		COLUMBIA	1 □ Yes 2 No
	th with t	Funeral Director	10e. Street and Number 5400 VANTAGE POINT ROAD	10f. Zip Code 21044	10g. Citizen of What Country? USA
036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hyglene. I Health and Mental Hyglene. Item 27 is marked other than "natural", or Items 23s or 28s-(show Item 27 is marked other than "natural", or Item and the nutilised at other traumatic event, If a Medical Exaction or the nutilised at	þ	11. Marital Status 1 Never Married 2 Married 3 Never Married 4 Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates: WWII	13. Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto	acify Yes or No-Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: WHITE
21215-0036	vithin 72 ho ne. han "natur n Medical	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	6a. Decedent's Usual Occupation (Give kind of work done during most of work IRECTOR OF N.Y. STATE	INCOME
Maryland 2	ould be filed withln Mental Hygiene. arked other than ' atic event, II a Ma	To Be Co	17. Father's Name (First, Middle, Last)	TAX 18. Mother's Name ROSE DEA	STATE OF NEW YORK (First, Middle, Maiden Surname) AN
lary	2 should be and Mental Is marked sumatic ev	-			al Route Number, City or Town, State, Zip Code)
	1 and Health iem 27 other tr		DR. JOHN F. DONOVAN, JR./SON 20a. Method of Disposition 20b. Plac		COLUMBIA, MD 21044-9450 Date 20c. Location - City or Town, State
altimore,	Pages nent of ant: If it ary or o		1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State cem	etery, crematory or other place) PETER'S CEMETERY 1/16	5/2006 TROY, NEW YORK
Balti	permit. Pages Department of Important: If I any Injury or once.		21. Signature of Euneral Service Licensee		E JOHNSON FUNERAL HOME, P.A.
			23a. Part . Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line.		
E	Physician	1	Immediate Cause (Final disease or condition	LOCK	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequent	nce of):	2 days
		ner	Sequentially list conditions, if any, leading to immediate trus. Finter lin ethyin Cause (Disease or injury	nce of):	2days
V	be executed sician and burlal-transit	Examin	Cause (Disease or injury that initiated events c	nce of):	
8760,	cate be executed physician and the burial-transit	dical E	d		
.O. Box 68	The law requires that the death certificate has been signed by the attending plage 2 should be detached for use as t	Physician/Med		eath 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
<u>a</u>	es that tigned by	by Ph		ng in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
ords	w require been sig should b				1 Yes 2 No 3 Probably 4 Nnknown
Records,	hasbuge 2sh	Completed			24a. Was an autopsy parformed? 24b. Were autopsy prior to completion of cause of death?
Vital		(d)	25 Was case referred to medical	26. Place of Deat	1 Yes 2 No 1 Yes 2 No
of V	this al di	To B	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 X EF		me 5 Residence 6 Other (Specify)
Ou		tion:	27. Manner of Death 28a. Date of Injury 1 Natural 5 Pending 2 Accident investigation	Bb. Time of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how injury occurred
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At hombuilding, etc. (Specify)	e, farm, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical (edge, death occurred at the time, date and place, n and/or investigation, in my opinion, death occur	and due to the cause(s) and manner as stated. red at the time, date and place, and due to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
•	100 10		30. Name and address of person o completed cause of death (Item 2	D 0057177	How 12 2006
	10+1		04 B to 61 d 44 out B to 14 out B		mbia MD 21044
*1	St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's Signatur JAN 1 7 2006	C Society	
DH	IMH 17 Rev 1/	2001		The same of the sa	
			0	RIGINAL	

		1	For State Registrar	State of I	Marylan		artment of H		nd Ment		20 0	6 (00710
	Physicia /Medic		1. Decedent's Name (First, Middle, La James H.		Jr.				M	ate of Death onth	Day 13 3	Year 2006	3. Time of Death 15: 44 M
	Examin		4a. Facility Name (If not institution, given Str. Admos Hospina)	re street and numb	er)		4b. City, Town, or Bouth	Location of	Death		4c. Coun	ty of Death	nore
	Funeral Director			Sex 7. 1]X∏ M 2 ☐ F	Age (In yrs. i	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (N	ate of Birth fonth, Day, Y	(ear)	Coun	place (State or Foreign htry) MD
Maryland	-f show		Usual Residence of Decedent 10a. State 10b. County MID			y, Town or Lo timore						1	0d. Inside City Limits 1X1 Yes 2 ☐ No
with the	3a or 28e il be noti	Il Direc	10e. Street and Number 5603 Selford Road	d			10f. Zip Code 21227			100	g. Citizen of	f What Cour	ntry?
036 urs after death	Department of Health and Mental Hygiene. Important: If them 27 is or 28e-f show important: If them 27 is marked other than "natural; or items 23e or 28e-f show any injury or other treumatic event, If a Medical Ever it ar must be notified at 90ce.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 17 Yes 2 If Yes, Give Year or Date	es?	'	Was Decedent of H f Yes, specify Cuba I ☐ Yes 21/2 No	ispanic Origi an, Mexican, Specify:	in? (Specify Y Puerto Rican	'es or No- , etc.)	BI	ace - Americ lack, White,	etc.
Maryland 21215-0036	ene. then "natura te Medical E	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation		16a. Deced (Give life.	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of			Stysco	Business/Ind	dustry
and 2	ental Hygi ked other c event, L	To Be Co	17. Father's Name (First, Middle, Las James Howard Dors	•			720	18. Mother	s Name (Firs 1 E. M	t, Middle, Ma	uiden Suma	ame)	
Mary nd 2 show	Ith and M 27 Is marl r treumati	-	19a. Informant's Name/Relationship Sheree Dorsey / V				ng Address (Street				•		Code)
Baltimore,	ent of Hea nt: If Item ry or other		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 (4 □ Donation 5 □ Other (Spec		ate c	Place of Dispo emetery, crer	sition (Name of matory or other place Memorial 1	(e)	Date	20	c. Location	a-City or To	
Balti permit.	Departm Importal any Inju		21. Signature of Funeral Service Lice	nsee	MO1378	22 G	Name and Addre	ss of Facility an Funer	ral Home	at Mea	dowrid	oe Memo	rial Park, IN
	iysic i an Medical		23a. Par Enter the disease or c syck, or heart failure ist of lmm diate Cause (Final disease or condition resulting in death)	a arvr	sed the death th line.	h. Do not ent							Approximate Interval Between Onset and Death
ecuted	xaminer al-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. astro	as a conseq	uence of):						1	nutry
		dlcal	IE EEMALG:	d .									
I Records, P.O. Box 6 The law requires that the death certif	ed by the attending detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		h 2∏Feta nt at time of d	Ideath 3	Ectopic pregnancy Other (specify)	<i>'</i>				Date of delive Month	ery Day Year
ords, P.	been signed b should be deta	þ	Part II. Other significant conditions	contributing to dea	th but not res	ulting in the u	nderlying cause giv	en in Part I.	2		cco use co		ne cause of death?
	cate has be	Completed								4a. Was an autopsy performe		prior to cor death?	psy findings available mpletion of cause of
of Vita	s certif director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Flor	nationt 2 🗆	ER/Outpatier	nt 3□ DOA Oth	or	of Death (Che sing Home			ther (Specifi	iv)
Vision of	After fune		27. Manner of Death Natural Accident Natural Natural Natural Natural	28a. ate of (Month,		28b. Time o Injury	28c. Injur Wor	y at	28d. [Describe how			,,
5 6	i Site	Certification:	3 ☐ Suicide 6 ☐ Could not determine	d 200. Flace 0	f Injury - At ho , etc. <i>(Specif</i>	ome, farm, sti fy)	eet, factory, office		28f. L	ocation (Stre lity or Town,	et and Nur State)	nber or Rura	al Route Number,
] Ihe Hospitel	within 24 hours a To the Funerel C completely filled	edical	29a. Certifying F (Check only one) Certifying F	Physicien: To the baminer: On the bas and manne	est of my kno is of examina r stated.	owledge, deat ation and/or in	h occurred at the tir vestigation, in my o	ne, date and pinion, death	place, and do	ue to the cau the time, dat	se(s) and r e and place	manner as s e, and due to	tated. o the cause(s)
Ţ		Σ	29b. Signature and title of certifier	M			29c. Licens	re number	0			ned (Month.	
104	d		30. Name and address of person wh	Completed cause	of death (Ite	324 JAB	Eiten A	ienu	2 Ba	thmc	re, r	ub a	1229
	St Regist	ate rar	31. Date filed (Month, Day, Year) JAN 1 7		istrar's Signa	ature	Coards)				ŧ		

			For State Registrar	tate of Maryla		artment of H			giene Reg. No. ())6 (007	
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Robert Drake					2. Date of Dea Month 01/12/0	Day	Year	3. Time of 1:34.	Death
r r	Examin		4a. Facility Name (If not institution, give stree 2010 Quay Village Ct	. #101		4b. City, Town, or Annapoli	LS	th	4c. Count Anne	y of Death Arunde	el	•
	Funeral Director		5. Social Security Number 6. Sex 474-20-0770 1X M	7. Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		y, Year)	9. Birthpli Count Minne	ace (State of try) 250ta	r Foreign
	Maryland s-f show	tor	10a. State 10b. County MD Anne Arunde		ity, Town or Lo		-		-	10	0d. Inside Cit	-
	h with the 23s or 28e	Funeral Director	10e. Street and Number 2010 Quay Village Ct	. , #101		10f. Zip Code 21403			10g. Citizen of	What Count	•	
020	iges 1 and 2 should be filed within 72 hours atter death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other then "neturel", or Items 23s or 28e-f show or other freumatic event, the Mardical Examble must be rediffed at	þ	1 Never Married 3 Married	Was Decedent Ever in I Armed Forces? IX□Yes 2 □ No If Yes, Give Year or Dates:1943-		Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S In, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	Bla	ice - America ack, White, e ify:White	etc.	
701717	ed within 72 h ygjene. ier then "netu t, the Medical	Completed		on mpleted) College (1-4or 5+) 5+	(Givə lifə. l	dent's Usual Occup kind of work done o DO NOT use retired	during most of wo		Depart of Def	mant ense	ustry	
ylalld	ould be fill Mental Hy wrked oth	To Be	17. Father's Name (First, Middle, Last) Ralph Drake				Helen F					
e, Mar	1 and 2 sh Health and Im 27 is rr Iher treur		19a. Informant's Name/Relationship (Type, MaryPage Drake / Wiff 20a. Method of Disposition	e	2010	ng Address (Street and Quay Vill string (Name of			napolis	, MD 2	21403	
Dallimor	t. Partmer		1 ☐ Burial 2/CXCremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	oval from State	etro Cr	ematory or other place ematory	01/	16/05	20c. Location	ville,	, MD	
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	Physician /Medical Examiner		nock, or har ailure. List only one commendate Cause (Final disease or condition resulting in death)	ause on each line. Metastati Due to (or as a conse	· Mel	anoma +		. ,			Interval Bety Onset and D	ween
9/00,	certificate be executed rding physician and use as the burial-transit	dical Examiner	Sequentially list conditions, large, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	Due to (or as a conse								
O. Box 68	ath certific attending p tor use as	Physician/Med	in the past 12 months?	If yes, outcome of pregi 1□Live birth 2□Fe 4□Pregnant at time of 9□Unknown	tal death 3	Ectopic pregnancy				ate of deliver	_	/ear
as, r.	wrequires that the de been signed by the should be detached	by	Part II. Other significant conditions contrib	uting to death but not re	esulting in the u	nderlying cause giv	en in Part I.		obacco use cor			
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DIVISION	el or Attendis s after death. if Director: A id in by the fu	Certification:	a Could not be	28e. Place of Injury - At building, etc. (Spec	home, farm, str	eet, factory, office		28f. Location (S City or Tow	Street and Num m, State)	ber or Rural	Route Numb	ber,
	To the Hospitel or Att within 24 hours after of To the Funerel Direct completely filled in by	Medical C	29a. Certifier 1 PCertifying Physici (Check only one) 1 Medicel Examiner:	an: To the best of my kr On the basis of examir and manner stated.	nowledge, death nation and/or in	n occurred at the tin vestigation, in my o	ne, date and plac pinion, death occ	e, and due to the ourred at the time, o	cause(s) and m date and place,	anner as sta , and due to	ated. the cause(s))
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	100		30. Name and address of person who comp Keith Dainsker,	mo 1390			nd Rosal	Amapoli	Janua 3, MD	2140	1	
	Sta Registi		31. Date filed (Month, Day, Year) 7 20	32. Registrar's Sign	nature	Soule		,, ,,	ş			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 9, 2606 Tanuary **Physician** 3:45A M Eugene /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Doctors Community Hospital Lanham Prince George's 7. Age (In yrs. last birthday) | Hunder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) Days 1⊠M 2□F Months Hours Yrs. 439-14-7760 86 July 19, 1919 Louisiana Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 11 Yes 2 □ No New Orleans Louisiana Orleans Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 70122 4208 Duplessis Street United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status I ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🖾 No δ Specify. 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Laborer Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter Eugene, Sr. Cecelia Donley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4208 Duplessis St., New Orleans, LA 70122 Esther Eugene 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Providence 4 □ Donation 5 □ Other (Specify) Jan 14, 2006 Metairie, Louisiana Memorial Park 22. Name and Address of Facility
Heritage Funeral Directors
4101 St. Claude Ave., New Orleans, LA 21. Signature of Funeral Service Licensee 70117 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure it ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition herniation Acute brain hours resulting in death) Subdural noud Sequentially list conditions, I any, I admit g to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Falls resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Chronic renal years IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year 4 Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No To Be 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural
2 Accident Injury 5 Pending 5:30PM investigation 1 🗌 Yes FALL 108/06 Suicide 6 □ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1810 LAKECKEST - DRIVE HOME - KITCHEN CLEOK FLL NO 30210 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

Pnysician /Medical Examiner The law requires that the death certificate be executed as the burial-transit the attending physician P.O. Box 68760 nse signed by the a d be detached for Division of Vital Records, peen has certificate or Attending Physicien: this in by the funeral After death. after death Hospitel 24 hours a per completely within 2 To the ţ

Funeral

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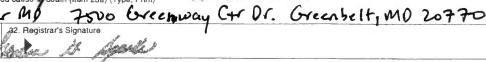
James

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

29b. Signature of title of certifier



who completed cause

ORIGINAL

eam (Item 23a) (Type, Print)

29c. License number

022780

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 0 ,__ **Physician** 2006 January 1:30A M P. Evans Grace /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Sykesville Carroll 111 Schoolhouse Road If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** 1 ☐ M 2√2 F Yrs. 84 Director 215-26-1162 Aug 26 1921 Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ont: If item 27 is marked other then "natural", or Items 23s or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State treumatic event, the Medical Examiner must be notified at 1 Yes 2 No MD Carroll Sykesville Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 111 Schoolhouse Road 21784 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nellie Hanna Clarence Rosier 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 111 Schoolhouse Rd., Sykseville, Md 21784 Carmella Evans Executor other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Gurial 2 ☐ Cremation 3 ☐ Removal from State 0 Department of Importent: If any injury or 3-04 * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee HAIGHT FUNERAL HOME & CHAPEL, PA 19 alex ruan Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arresponds, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 25 Physician 250 /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown signed by 23e. Did tobacco use coptribute to the cause of death? Part II. Other significant conditions contributing to death but-not resulting in the underlying cause given in Part I. Division of Vital Records, by Heart 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate has 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 ☐ Yes 2 ☑ No 5 Vesidence 6 □Other (Specify) 2 this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 VNatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of D16206 10 2006 Name and address of person who completed cause of death (from 23a) (Type, Print) VALLAN 1380 Vaco Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 1 7 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie] 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician 6:50AM E. FOSTER PATRICIA JANUARY 12 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Him Or e par If Under 24 Hrs. Bon ecour If Under 1 Year 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min Months 212-56-1 M 25 F Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show The Medical Exerciser must be notified at 1 Mes 2 No Director Baltimore Md10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3202 21216 , or items 23a Ton Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ♣No Specify. Specify: Black þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other then any injury or other traumatic event, the Magangones. Elementary/Secondary (0-12) College (1-4or 5+) usekee ome stic 10 per . Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21224 19a, Informant's Name/Relationship (Type, Print) 3919 brother oster 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Heart acred 2006 4 ☐ Donation 5 ☐ Other (Specify) em Carlon Cullun St. 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ENCEPHALOPATKY **Physician** HEPATIL DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 132FED DAYS GASTRO-JNTESTINAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine this certificate has been signed by the ettending physicien and rat director, page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed CUAGULDPA 4N×NOWA Division of Vital Records, P.O. Box 68760, resulting in death) Last Due to (or as a consequence of): CIRRKOSIS ZNKNOWA Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ A-5C1713 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ② Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No : After this certifical funeral director, p Hospitel or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Cther: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 12 No 1 inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fund completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD. JANNARY D 23300 06 SFLOURS HOSP. BON 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PATEZ. BALTI, MD, 21223 2011W. SUDKIR, 7. BAZTO 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar JAN 1 7 2006

		1 - For State Registrar	State	of Marylar		artment o	f Health and of Death		giene	6 0	0715
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Funer		5. Social Security Number 6	.Sex 1XM 2□F	7. Age (In yrs.	last birthday)	If Under 1 Ye Months Da		n. (Month, Da	h v. Year)		lace (State or Foreign try)
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Division of Vital Records, alor Attending Physicien: The law requires to the defending Physicien: The law requires to the record Affer this certificate has been signed in by the funeral director, page 2 should be or	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	286. Plac	e of Injury - At he ling, etc. (Specil		eet, factory, offi	ice	28f. Location (S City or Tow	Street and Num m, State)	nber or Rurai	Route Number,
Division of Vital Records, P.O. Box 68 To the Hospitel or Attending Physicien: The law requires that the death certifica within 24 hours after death. To the Funaral Director: After this certificate has been signed by the attending pla completely filled in by the funeral director, page 2 should be detached for use as t	edical C	29a. Certifier 1 Certifying (Check only 2 Medical Ex	eminer: On the l	e best of my kno pasis of examina nner stated.	owledge, deat ation and/or in	h occurred at th vestigation, in r	e time, date and plac ny opinion, death occ	ce, and due to the courred at the time.	cause(s) and r date and place	manner as sta e, and due to	ated. the cause(s)
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		Mula Xa	Ma	MD		Do	003274	14	Janua	411.	2006
15+1		30. Name and address of person wh	o completed cau	se of death (Item	п 23a) (Туре,	Print)	003274 GLEN	Rais	110	21061	
	State	31. Date filed (Month, Day, Year)	32.1) 001 f Registrar's Signa	IUSY (T)	AL BR	07-21U	DUKIU1 &	MU	W1001	
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State of Maryland / Department of Health and Mental Hygiene] [] Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 13, 2006 TANUARY **Physician** 8:45 A MARY CONSTANCE RYAN FURST /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Saint Joseph Medical Center Towson | House 1 Year | Hours | Min. | 8. Date of Birth (Month, Day, Year Jun 16, 19) Birthplace (State or Foreign Country)
 New York 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2 🛱 F 76 212-32-8448 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f ehow other traumatic event, the Medical Example rimplified at 1 √2 Yes 2 □ No **Baltimore** N/A Directo Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ŏ 21211 USA 830 West 40th Street or Iteme 23a Completed by Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced "naturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. snt: if Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Own Residence Homemaker 4 yrs 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Elizabeth Rvan James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2003 Gouth Street, Baltimore, Maryland 21231 (Son) James F. Furst 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of himportant: If Ite any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley M. Grdns 1/16/06 Timonium, Maryland 21. See at 15 of F and Service (Conset 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc. Martin D. Lawson

6500 Yerk Read, Raltimere, Maryland 21212

23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Approximately a constant of the co Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DAYS **Physician** RESPIRATORY FAILURE /Medical Due to (or as a consequence of): YEARS PULMONARY FIBROSIS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and s the burial-transit The law requires that the death certificate be executed MALNUTRITION Due to (or as a consequence of). P.O. Box 68760 PNEUMONIA, ASPIRATION Physician/Medicai attending p as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Year Month in the past 12 months?
1 Yes 2 No
9 Unknown Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. ð 2 No 3 Probably 4 Unknown RESPIRATORY ACIDOSIS Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 20 No 210 No 1 Yes Division of Vital or Attending Physician: after death. Director: After this certifice 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 □ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: Natural 5 Pending 2 Accident the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 | Homicide To the Hospitel o within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2006 D Ø15414 20 30. Name and address presson who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE TOWSON MARYLAND 21204 M. D. NGUYEN 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			For State Ragistrar	State of Ma	rylan		artmer			ind M	,	giene Reg. No.	006	00717	
	Physici	an	Decedent's Name (First, Middle, La ELIZABE		F.	· · ·	FRI	EDMAI	N		2. Date of Dea Month JANUAR		2006	3. Time of Death 9:45 Å M	_
	/Medic Examin		4a. Facility Name (If not institution, giv		1 •				Location o	f Death	071110711		ounty of Deat		
	Examin	ei		ARE RUXTON					TOW	SON			BAL	[IMORE	
	Funeral		5. Social Security Number 6. S	Sex 7. Age		last birthday)	If Unde Months	r 1 Year Days	If Under 2		8. Date of Birt (Month, Date	h v. Year)	9 Birt	hplece (State or Foreign	7
	Director			1□M 2₩F		92 Yrs.	I VIOTALI I O	5-,0	110010		JUL, 16	,1913	3	" FL	_
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation						-,-,-	10d. Inside City Limits	
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	r 28a	Director	10e. Street and Number			5,12		Code				10g. Citize	n of What Co	untry?	_
	death with the Maryland me 23s or 28s-f show if must be notified at		3408 OLD POST	DRIVE					212	80				USA	
	eme 3	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.	S. 13.	Was Dece	dent of His	spanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)	14	. Race - Ame Black, White		_
9	or it	by Fu	1 Never Married 2 Married	1 □ Yes 2 🛣 N If Yes, Give	0	1	1 □ Yes		Specify:		, ,		pecify:	WHITE	
9500-61212	72 hours after "natural", or ite	d be	3 X Widowed 4 □ Divorced	Year or Dates:		16a. Dece	dont's Her	al Occupa	ution.			16h Kind	of Business/		
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77	yene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	SECI	RETAR	Υ				MED]	CAL		
	e filed al Hygic other vent, I	BeC	17. Father's Name (First, Middle, Last	O .					18. Mothe	r's Name	(First, Middle,	Maiden Si	umame)		
<u>a</u>	Mente Mente arked	70	LEON			FISI	HEL		BE	SSIE				NEUHAM	
Maryland	s 1 and 2 should f Health and Mer item 27 is mark other traumatic		19a. Informant's Name/Relationship				_				I Route Numbe				
	l and lealth im 27		MICHAEL FRIEDM	AN / SUN	20h F	3408 Place of Dispo					BALTIM		MD 212		_
2	Pages 1 nent of h int: if ite		20a. Method of Disposition 1 Disposition 2 Cremation 3 [0	emetery, crei	matory or	other place		.K	7-2-0		- 101		
altimore,	it. Pa intmer intent njury		* 4 □Donation 5 □ Other (Special Signature of Funeral Service Lice		UH	EB SHAI			IAL s of Facility		6/2006			STOWN, MD	_
Ba	permit. Pages Department of Important: If i any injury or once.		21. Signature of Furieral Service Lice	7	- 2					30	L LEVIN			, INC. , MD 21208_	
			23a. Part1. Enter the disease, or con	nplications that caused	the deat								OVILLE.	Approximate	_
	Physician		shock, or heart failure. List only Immediate Cause (Final	13		2001	110		, , ,	> 7	TUB	1410		Interval Between Onset and Death	
tic;	/Medical		disease or condition resulting in death)	a. Due to (or as a			773	CM I	-71		HRO	1136	03/5	Menths	_
Е	Examiner		Sequentially list conditions.	b. angl		STrol	re								,
14	D is	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	a conseq	uence of):									
10	be executed icien and burial-transit	xam	Cause (Disease or injury that initiated events resulting in death) Last	C Due to (or as a	CORSO	neuce ot).									
760,	ate be executed hysicien and the burial-transit	calE													
	ficate phys s the			. d											_
Вох	anding use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			76-4	741				23	d. Date of del	ivery	
m	death e atte	ICIa	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at			□Ectopic p □ Other (s						Month	Day Year	
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Ś	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as if	by	Part II. Other significant conditions	contributing to death bu	ut not res	ulting in the u	inderlying	cause give	en in Part I.					the cause of death?	
ord	w requir been si should I	ted									10'	res 2 🗆	No 3 □ Pr	obably 4 Unknown	-
ec	has b	Completed									24a. Was		24b. Were au prior to death?	itopsy findings available completion of cause of	9
a H												2No		2 □ No	_
Ž	Attending Physician: r death. ector: After this certifics by the funeral director.	Be C	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	0	CD/O 4		Othe Othe			(Check only o		7011	7.1	_
ō	Physical distribution	. To	1 ☐ Yes 2 No 27. Manner of Death	1 ☐ Inpatie 28a. Date of Injur (Month, Day		ER/Outpaties 28b. Time o		28c. Injury Work			me 5 Resident			сиу)	
<u>0</u>	nding ath. r: Afte e func	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		(Year)	Injury	М		<br Yes 2 □ I	No					
Division of Vital Records,	Atternation of the part of the	Certification:	3 ☐ Suicide 6 ☐ Could not determined	be 28e. Place of Inju	iry - At h	ome, farm, st	reet, facto	ry, office			28f. Location (S		Number or Ri	ural Route Number,	_
ā	ital or A	Cer								- Indiana					
	To the Hospital or Attending Physician: within 24 horus after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier 1 Cartifying P	Physician: To the best of minar: On the basis of	of my kno examina	owledge, deat ation and/or in	th occurred ivestigation	d at the tim	ne, date an pinion, dea	id place, th occurr	and due to the red at the time,	cause(s) a date and p	nd manner as lace, and due	s stated. to the cause(s)	
	thin 2 the the	Med	one) 29b. Signature and title of certifier	and manner sta	ited.			c. License						h, Dey, Year)	
)	F % F 8		AH	alad						04	ia	1-	1-3-1	96	
	1		30. Name and address of person who	completed cause of d	eath (Iter	n 23a) (Tvna	Print)	~ ~(1	0	/	,			
	V		A.H. GHILA	D1.141D.	7	600	05	161	P 2	Dr.	Vons.	ON	1710	21204	
	Sta		31. Date filed (Month, Day, Year)	- 32. Ranistra	ar's Signa	ature	10								
196	Regist	rar	ENN 1 P	2000	W.	MA	10046								

DHMH 17 Rev 1/2001

ORIGINAL

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

511 ECB.

2006

CROSSKUADI DR. UWINCS 23 MA 32. Registrar's Signature

29c. License number

110246

29d. Date signed (Month, Day, Year)

12/2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 12 2006 14:40 CM FELDMAN **Physician** BORIS /Medical 4a. Facility Name (If not institution, give street and number)

SINM HOSPITAM OF BATTIMORE 4c. County of Death 4b. City, Town, or Location of Death Examiner BALT (MORE aty N/A 9. Birthplace (State or Foreign 8. Date of Birth
JUN. 30, 1931 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex Days **Funeral** Min 1 M 2 □ F 74 ÜKRAINE 214-43-8182 Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "naturel; or Itema 23a or 28a-f show any Injury or other traumatic event. The Wedical Experiment and be notified an once. 10a State 1 ☐ Yes 2 No REISTERSTOWN Director BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number USA 21136 124 SHROPSHIRE COURT Funerai 14 Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 💢 If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2 💢 No WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify þ 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Flementary/Secondary (0-12) **ENGINEERING** MECHANICAL ENGINEER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be KESSELMAN STYCCYA FELDMAN MENDEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 124 SHROPSHIRE COURT - REISTERSTOWN, MD 21136 IDA ELBERT / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🂢 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) REISTERSTOWN, MD BALTIMORE HEBREW CEM. 1/15/2006 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final metastatic lung cancel 3 months **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-transit The law requires that the death certificate be executed attending physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No NA certificate has the irrector, page 2 s 1 ☐ Yes 21 No or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA ဥ After thi 28d. Describe how injury occurred Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: / 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Illed in by 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medica (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RE3-000 2006 MO MAYAM

DHMH 17 Rev 1/2001

State Registrar

FELDMAN

KNOWN

Smai

, MD

32. Registrar's Signature

Mospital of Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMDORSKY

2006

SAMUEL

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
Amend Tem 5 per inf 2051 1-20-06 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year HASKEL JANUARY 10, 2006 FREEDMAN /Medical 6:09 P 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1000 NOTCHCLIFF ROAD GLEN ARM BALTIMORE 5. Social Se 215-216-If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year, -24-5482 -32-4163 7. Age (In yrs. last birthday) 6. Sex Funeral Birthplace (State or Foreign Country) 1**☆**M 2□ F 74 Director MAY 3, 1931 MD Usual Residence of Decedent 10a, State 10b. County 28e-f ehow 10c. City, Town or Location event, the Medical Examiner must be notified at 10d. Inside City Limits Directo MD N/A 1 Yes 2 □ No BALTIMORE the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 6221 EVERALL AVENUE or iteme 23a 21206 filed within 72 hours after death by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 XYes 2 □ No If Yes, Give Year or Dates: altimore, Maryland 21215-0036 **KOREA** 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced WHITE Specify: "naturel", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Cotlege (1-4or 5+) SALESMAN HOME IMPROVEMENT Pages 1 and 2 should be filed nent of Health and Mental Hyginant: If item 27 is marked other 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) 2 MAURICE other traumatic FREEDMAN CECELIA BRIGHTSTEIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MYRA SACHS / DAUGHTER 2903 TANEY ROAD - BALTIMORE, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) CHAIM) 20a. Method of Disposition Date 20c. Location - City or Town, State = 5 1 ■ Burial 2 Cremation 3 Removal from State permit. Page Department important: any injury o once. 4 ☐ Donation 5 ☐ Other (Specify) ANSHE EMUNAH (AITZ 01/13/2006 HALETHORPE, MD 21. Signature Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part / Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or head failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) **Physician** GUN SHOT WOUND TO HEAD 5 minutes /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit Exami and Due to (or as a consequence of): Box 68760. physicien Physician/Medical as the attending for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day P.O. I signed by the a Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗙 No 3 Probably 4 Unknown peen has 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform this certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No Physicien: in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Automob; 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural Self inflicted gun shot wound

28t. Location (Street and Number or Rural Route Number,
City or Town State) Heriff Rd 1057 5 Pending death. Zenuary 10, 2006 1809 P M 1 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 2 Accident investigation 1 Yes 2 No Director 6 Could not be determined 3 Suicide 4 Homicide hours efter Automobile To the Hospitel completely filled Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical - 24 (Check only one) within 2 To the 29b. Signature and little of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 1018667 January 11,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7 Philip Militello, MD 6 Trimble H:11 CT. Lutherville, Maryland 21093 31. Date filed (Month, Day, State 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Physician 2000 8:00 am (rambrell Jan. /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner Windson Mill Estimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Davs | Hours | Min. | Month, Day, 7. Age (In yrs. last birthday)
Yrs. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Months Yrs. Carolina cut Usual Residence of Decedent 10d. Inside Lity Limits 10b. County 10a. Stete 10c. City, Town or Location Windson 1 Yes 2 No Maryland Director 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Eyer in U,S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Meritel Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: Specify: Blac 1 Never Married 2 Merried 1 ☐ Yas 2 No Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupetion
(Give kind of work done during most of working life. DQ NQT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SuburbanCountr Grad 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be B. F. Gambrel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Neme/Relationship (Type, Print) Vargis Gambre Michael 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date 1 DBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CANDIOVAS CUCAU . AUTEMOSCUENOTIC DISCA SE Due to (or as a consequence of): Examine Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Physician/Medical Due to (or as e consequence of): Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HYPENTENSIN à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed DIABETTS MELLINS HYPENCHIES PONOLEMIA 1 🗆 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 1 Yes 2 No Certification: To 5 Residence 6 □Other (Specify) 28c. Injury et Work? 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Physician /Medical Examiner cartificata be axecuted P.0. Division of Vital Records,

Funeral

Director

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Pagas 1

Baltimore, Maryland 21215-0036

To the Hospital or Attending Phys within 24 hours aftar daath.

To the Funerel Director: Aftar this complataly filled in by the funeral di

State Registrar

Medical

(Check only

29b. Signature and title of certified

GBMC Weinber

31. Date filed (Month, Day, Year)



BANBANA SANICO NO

1200 E. PAYETTE

and manner stated.

30. Name end address of person who completed ceuse of deeth (Item 23e) (Type, Print)

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29c. License number

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29d. Date signed (Month, Dey, Year) 10

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State of Maryland / Department of Health and Mental Hygiene

				Oldio or IVI	ai yiai ia		ficate of	Death	Wienian	Reg. No.	b	00122
		1. Decedent's Name (First,	Middle, Last)						2. Dete of De	eth		3. Time of Death
1	Physician	Virginia	L. Gr	eenawalt					Januar	Dey v 3 2	Year 2006	6:43 pm
	/Medical Examiner	4a Facility Neme (If not inst						4b. City, Town, or				- 0 13 pm
7		Fort Washi	ngton	Medical	Center	r		Ft. Wash	ington	Princ	e Ge	orge
>*	Funeral	5. Social Security Number	6. Sex		e (In yrs. las	t birthday)	If Under 1 Year Months Deys	Ft Wash If Under 24 Hrs Hours Min	/Month Da	th V Year	9. Birthp	place (State or Foreign
	Director	578-44-4647		M ZEEF	72	Yrs.			Dec. 1	8, 1933	Wash	ington, DC
	Du a	Usuel Residence of Decede 10a. Stete 10b. Co		_	10c. City.	Town or Loca	tion				- 1	10d. Inside City Limits
	ahor s			0200		n Hill						1 Q Yes 2 □ No
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0	iges 1 and 2 should be filed within 72 hours after death with the Meryland to f Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Medical Examinar must be notified at To Be Completed by Funeral Director	1 Never Married 2	Married	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give			es, specify Cub Yes 212 No	dispenic Origin? (San, Mexican, Puer Specify:	rto Rican, etc.)	Blac Specify	k, White,	
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d 2	filed within Hygiene. other than ent, the M		ddle (ast)			Home	maker	18. Mother's Na	me /First. Middle	, Maiden Surnam		
an	ad be find H and out							Madeli		,	-7	
7	2 should be for end Mental His marked of raumatic every	Jack Grave		ne Print)		19h Mailing	Address (Street			er, City or Town,	State Zir	Code)
Baltimore, Maryland 21215-0020	nd 2 sulth er 27 is r trau	Edward W. Gre								Hill, N		20745
Je,	f Head	20a. Method of Disposition			20b. Plac	e of Disposit	ion (Name of tory or other pla	ce)	Date	20c. Location -	City or To	own, State
Ë	permit. Peges 1 end 2 Depertment of Health e Important: If Item 27 is any injury or other tra once.	1 ☐ Burial 2 🛣 Crema 4 ☐ Donation 5 ☐ Oth		emoval from State		-	1n Crem		1/13/06	Brentwoo	od, M	1D
alti	mit.	21. Signature of Funeral Se	rvice License	e, 1		22. 1	lame and Addre			ln Funer		
m	P P E E	Jan 7	1.51	il		340	1 Blade	nsburg R	d. Brent	wood, MI	207	22
		23a. Par(1. Enter the disease shock, or heart failure.	se, or complic	ations that caused	the death.	Do not enter	the mode of dyir	ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Between
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	/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a.	Athen	500	erotic	CARL	W45 am	lan H	eart Di	500	22-
н		resulting in death)			Due to (or a	s a conseque	nce of):				1	
	nlne		b .									
_	The law requires that the death certificate be executed ate has been signed by the ettending physician and page 2 should be deteched for use as the buriel-trensit completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury			Due to (or a	s a conseque	nce of):				į	
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1	Physician: rthis certific oral director, To Be (examilier? 1 ☐ Yes 2 ☐ No	Ho	ospital: 1 🗀 Inpatie	nt 2DEP	?/Outpatient	3□ DOA Oth	er: 4 Nursing I	Home 5 ☐ Resi	dence 6 □Othe	r (Specif	y)
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0	Attanding or death. ector: Afte by the fune ifficatior	2 Accident in	vestigetion				M 1	Yes 2 □ No				
Division	tal or Attanding P rs after death. si Director: After t ied in by the funers Certification:	3 ☐ Suicide 6 ☐ Co	ould not be etermined	28e. Place of Inju- building, etc		e, farm, stree	, factory, office		28f. Location (City or To	Street and Numbe vn, Stete)	r or Rura	d Route Number,
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	To the Hospital or At within 24 hours efter of To the Funeral Direct completely filled in by Medical Certifi			cian: To the best of er: On the basis of end manner sta	examination							
_	Vithin Fo the somple	29b. Signature end title of ce	ertifier				29c. Licens	e number		29d. Date signed	(Month,	Day, Year)
		Aland	'w /	histo	12		Ho	00-	927			
	7	30. Name end eddress of pe	rson who con	npleted cause of di	eath (Item 23	3e) (Type, Pr	nt)	- > > '				
	U	Salvadon	Sy/wa	5 Em 3	001	1605 21	tel ?	Dive	Clover	& M.	mg.	land
	State	31. Date filed (Month, Day, 1	rear)	32/Registra	r's Signetur	Carte S				01		
	Registrar	JAN I	ZUUD A	Gallette 3	all fre							

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3 Time of Death 2006 4.45 PK **Physician** James Grady an /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not institution, give street and number) Examiner Silver Spring Montgomery Lavhill Center If Under 1 Year If Under 24 Hrs. 6. Sex 1 M 2 □ F 8. Date of Birth (Month, Day, NOV , Birthplece (State or Foreign Country)
 Ohlo 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Deys 74 Yrs. 289-26-9970 Director Usuel Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours efter death with the Meryland Depertment of Heelth end Mentel Hygiene. Important: If itam 27 is marked other than "natural", or items 23s or 28s-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Funeral Director Ellicott City Maryland Howard 10f. Zip Code 10g. Citizen of Whet Country? 10e Street and Number 21042 9757 Gingerwood Drive 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1∑ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White Be Completed by 3 Widowed 4 Divorced 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) University / Teaching Archaeologist 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Lois Keifer William Gradv 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9757 Gingerwood Drive Ellicott City, MD 21042 Anne Grady, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 1/16/06 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation Society Of Maryland Inc. Thomas Gregor 299 Frederick Road Baltimore, Maryland 21228 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** ementa Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Be Completed by Physician/Medical Examiner or Attending Physician: The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 No 25. Was cese referred to medical examiner? 26. Plece of Death (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpetient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury et Work? 1 Natural 2 Accident 5 Pending investigation 2 No 1 Yes il Director: Af ad in by the fu 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 \(\text{Homicide} \) To the Hospital within 24 hours a To the Funeral C completely filled 15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) end manner steted. 29a. Certifier (Check only one) and title of certifier 29d. Date signed (Month, Day, Year) 29b. Signature

State Registrar 31. Dete filed (Month, Day, Year)

32. Registrer's Signature

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30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print)

AN 1 7 2005

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32. Hegistrer's Signature

Loch

3altimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Chanel N. Gordon Unpend item# 23a,PH,27, pen/E,8833,3/18/05 II. Ensure All Copies Are Legible. Unpend item#23a,PII,27, penME,8853,3/18/U5 II

Amend item#23a,PII,penME,8850,6/29/06 Certificate of Death

Reg. No. 06-0280 AKG 1 - For Al State Registrar ent's Name (First, Middle Last) 2. Date of Death 3. Time of Death January 11, 2006 **Physician** 1:16 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northwest Hospital Randallstown Baltimore County | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral 5 1 □ M 2 KF 217-82-3307 Yrs. Director Usuel Residence of Decedent with the Maryland 10a 10b. Count 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Examiner must be notified at Director 1 ☐ Yes 2 No ilasi more 10f. Zip Code 10g. Citizen of What Country? teme 23a 108 Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. es 20 No Give Peges 1 and 2 should be filed within 72 hours after Never Married 2☐ Married ☐Yes Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during life. OO NOT use retire!) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) Hygiene. College (1-4or 5+) isa 0 ame (First, Middle) Be 18. Mother's Name (First, Middlet, Maiden Sumame and Mental le marked ordor nita Informant's Name/Relationship (Type, Print) 19b. Mailing Ad Less (Street and Number Gordon Department of Health Importent: If Item 27 Method of Disposition Burial 2 Cremation 3 Removal from State 21. Signature of Funeral/Service License any l 23a. Part1. Enter tro Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, with as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Discorder due to combine policy. Disorder due to cerebral palsy Immediate Cause (Final disease or condition resulting in death) **Physician** Complications of cerebral palsy /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physicien and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical ettending plant for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel dea 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
94☐ Unknown 2 Fetel death Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) ed by the e 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by -Cardiomegaly cardiomegaly \$<u>₩</u>0 1 Tes 3 Probably 4 □Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No page 2 s has autopsy performed? 1 X Yes 2□No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 X Yes 2 □ No 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 X Natural 5 Pending s after ou. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide within 24 hours after de To the Funeral Directo completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 12, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pamela E. Southall MD 111 Penn Street, Baltimore, Maryland 31. Date filed (Month, Day, Year) 32. Reistrar's Signature oute Registrar 2006

DHMH 17 Rev 1/2001

			For State of N		artment of Health and rtificate of Death	d Mental Hygie _j . Reg.4	2016 1111775
	Div. dat		Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death
	Physicia /Medic	al	BENJAMIN HOWELL GRIST				² 14, Ž ^o 006 8:01 p ^M
7	Examin	er	4a. Fecility Name (If not institution, give street and numbe 3615 HESS ROAD	7)	4b. City, Town, or Location of Di MONKTON		4c. County of Death BALTIMORE
	Funeral		5. Social Security Number 6. Sex 7. /	Age (In yrs. last birthday)	If Under 1 Year If Under 24 h	rs. 8. Date of Birth	9. Birthotace (State or Foreign
	Director		219-28-0362 \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	94 Yrs.	World's Day's Trouis IV	ocT.31,1	911 MARYLAND
	/land		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside City Limits
	e Mar	Director	MD BALTIMORE	MONKTON			1 ☐ Yes 2 No
	3a or 28	al Dire	10e. Street and Number 3615 HESS ROAD		10f. Zip Code 21111	10g.	Citizen of What Country? USA
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland t of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Modical Examinating rotal by recitive at	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Deceder Amed Force 1 Pyes 2 If Yes, Give Year or Dates	s? ⊒No	Mas Decedent of Hispanic Origin? f Yes, specify Cuban, Mexican, Pu 1 ☐ Yes 2 ☒ No Specify:	(Specify Yes or No- uerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE
2	72 ho	eted	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usuat Occupation kind of work done during most of	working 16b	. Kind of Business/Industry
12	within ene. than *	Completed	Elementary/Secondary (0-12) Cotlege (1-4c)	(ife. l	DO NOT use retired) ESTMENT BANKE!		NVESTMENT BANKING
Baltimore, Maryland 21215-0036	ild be filed fental Hygirked other fic event, I	To Be Co	17. Father's Name (First, Middle, Last) BENJAMIN H. GRISWOLD		18. Mother's I	Name (First, Middle, Maid IE MONTAGU	den Sumame)
Mary	and 2 should i ealth and Men n 27 is marke ier traumatic		19a. Informant's Name/Relationship (Type, Print) MICHAEL HANKIN atto:		ng Address (Street and Number of S • BOND ST •		
more,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other trau	İ	20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from Sta 1 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disponsion ST • JAMES	natory or other place)	Date 20c. 20c. 20/2006 MC	Location - City or Town, State
Balti	permit. Departri Imports any infu		21. Signature of Funeral Service Licensee	22	2. Name and Address of Facility 16924 YORK R		NKINS & SONS CO.
	ż		23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	line			Approximate Interval Between Onset and Death
	Pnysician /Medical		tmmediate Cause (Final disease or condition resulting in death)	uxe m	yo carclic Kuilure	el infas	rction
F	Examiner		Due to (or a	as a consequence of):	Vailure	,	
	P =	ner	Sequential y list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	as a consequence of):	position C		
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8760,	cate be executed physician and the burial-transit	dicalE	d				
9	tificate ng phy as the		V				
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<u>α</u>	res that the d signed by the be detached	by Ph	Part tl. Other significant conditions contributing to death	but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
rds	- 0, 0					1 🗆 Yes	2 No 3 Probably 4 Unknown
Records,	e law has b	Completed				24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
Vital	siclen: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?			Death (Check only one)	
of/	Phys this al dia	. To	1 ☐ Yes 22 No Hospital: 1 ☐ Inpa 27. Manner of Death 28a. Date of It			g Home 5 Residence	6 Other (Specify)
	Attending r death. ector: After by the funer	tlon	1 Natural 5 Pending (Month, 12 Accident investigation	Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No		, and the second
Division	for Atter after dea Director I in by the	Certification;	3 Suicide 6 Could not be 28e. Place of	Injury - At home, farm, str etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, late)
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	ledical C	29a. Certifier (Check only one) Certifying Physician: To the be 2 Medical Exeminer: On the basis and manner	s of examination and/or in	h occurred at the time, date and pi vestigation, in my opinion, death o	ace, and due to the cause courred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. License number		Date signed (Month, Day, Year)
)			Hours al	un	- DODLOT		LN.16.06
	10+1		30. Name and address of person who completed cause of HORST SCHIRMER, M.D.	1		EYSVILLE,	MD 21030
	Sta Regist		31. Date filed (Month, Day, Year) 32. Fig. 32. Fig. 32. Fig. 32. Fig. 32. Fig. 32. Fig. 33. Date filed (Month, Day, Year) 32. Fig. 33. Date filed (Month, Day, Year) 32. Fig. 33. Date filed (Month, Day, Year) 32. Fig. 33. Date filed (Month, Day, Year) 32. Fig. 33. Date filed (Month, Day, Year) 32. Fig. 33. Date filed (Month, Day, Year) 32. Fig. 33. Date filed (Month, Day, Year) 32. Fig. 33. Date filed (Month, Day, Year) 32. Fig. 33. Date filed (Month, Day, Year) 32. Fig. 33. Date filed (Month, Day, Year) 33. Date filed (Month, Day, Year) 32. Fig. 33. Date filed (Month, Day, Year) 33. Date filed (Month, Day, Year) 33. Date filed (Month, Day, Year) 33. Date filed (Month, Day, Year) 33. Date filed (Month, Day, Year) 33. Date filed (Month, Day, Year) 33. Date filed (Month, Day, Year) 33. Date filed (Month, Day, Year) 33. Date filed (Month, Day, Year) 34. Date filed (Month, Day, Year	strar's Signature	borki		

		4	State				artment of F rtificate of			Reg. No.	0 00120
£			Registrar 1. Decedent's Name (First, Middle	e, Last)					2. Date of De	ath	3. Time of Death
	Physicia	_	Gerald L.	Gaeger					Januar		06 6:20 p M
	/Medic Examin		4a. Facility Name (If not institution		um ber)		4b. City, Town, o	r Location of Dea	th	4c. County of	
	- 48	*35	2028 Rudy Seri				Sykes			Carro	
)#	Funeral		5. Social Security Number	6. Sex 1 X M 2 □ F		rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	(Month, Da	h y, Year)	Birthplace (State or Foreign Country) LTV
*	2 Director		234-50-2732 Usual Residence of Decedent		70) (1.5.			Jan. 1	7,1935	WV
	/land		10a. State 10b. County		10c.	City, Town or Lo	ocation				10d. Inside City Limits
	Man,	tor	MD Cari	co11		Sykes	sville				1 ☐ Yes 2 🔀 No
	or 28	irec	10e. Street and Number			· · ·	10f. Zip Code			10g. Citizen of Wh	at Country?
	23E	ral	2028 Rudy Ser				217			USA	
	er dez	Funeral Director	11. Marital Status	Armed F		n U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (an, Mexican, Pue	Specify Yes or No rto Rican, etc.)	- 14. Hace - Black,	- American Indian, White, etc.
20	rs afte	by F	1 ☐ Never Married 2 🛣 Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes. G	: 2 □ No Sive Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify:	White
3	filed within 72 hours after death with the Maryland Hygiene. other then "naturel", or Items 23s or 28e-f show ent. The Medical Erst in ser must ke rediffed at			nt's Education		16a. Dece	dent's Usual Occup	pation		16b. Kind of Busi	iness/Industry
מ ב	hin 73	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed	(1-4or 5+)	life.	kind of work done DO NOT use retire	during most of wo d)	orking		
7	ygient gient er th	Con		3		E	Estimator			MD Masor	
and	be file tal Hy doth even	Be	17. Father's Name (First, Middle,							Maiden Sumame))
7	ould Men narke	မ	Steven Nelson 19a. Informant's Name/Relations			10b Maili	ing Address (Street	l	se Knapp	er City or Town St	tate Zin Code)
<u> </u>	d 2 st th and t7 is r treur		Marsha Lynn Ga		Wife		Rudy Se				
a)	Heal Heal tem 2		20a. Method of Disposition	reger			osition (Name of ematory or other pla		Date	20c. Location - C	
Saltimor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23s or 28e-1 show any injury or other treumetic event. The Medical Errarities final Le notified at one.		1 XBurial 2 ☐ Cremation 1 4 ☐ Donation 5 ☐ Other (5		11 State		ew Mem. P		6/06	Sykesvi]	lle. MD
	nait. F partm porter rinjur		21. Signature of Funeral Service		11		2. Name and Addre				rstown Road
ñ	P P P P P P P P P P P P P P P P P P P		Sepher	m ye	2nK	ins I	Eline Fun	eral Hom	e Reis	terstown,	, MD 21136
i	•		23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that							A managed the sales
				t only one cause on	t caused the d Leach line.	leath. Do not en	nter the mode of dying	ng, such as cardia	ac or respiratory a	rrest,	Approximate Interval Between
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	Di		Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year 3. Time of Death
	Physici /Medio		EVE MARIE GALL	OWAY	JAN. 13	
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death WESTMINSTER		4c. County of Death CARROLL
	Funeral		CARROLL LUTHERAN VILLAGE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign
	Director		453-14-0234 ^{1□M 2} ♥F 89 Yrs.	Months Days Hours Min.	(Month, Day, Ye 9 / 1 6 / 1 9 1	ar) Country)
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Li	ocation		10d. Inside City Limits
	Maryl f sho	tor	MD CARROLL WESTM	INSTER		1 ZYes 2 □ No
	h the	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	ath will	ralD	47 WEST MAIN ST.	21157		usa
	ltems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ₹ No	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
036	within 72 hours after death with the Maryland one. Than "natural", or Items 23s or 28s-f show the Madical Examiner must be notified at	þ	3 ☑ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: WHITE
5 0	72 ho	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of workin	16b	. Kind of Business/Industry
7	han "	mple	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired) HOUSEWIFE		IOME MAKER
Q 0	filed with Hygiene other tha	e Co	17. Father's Name (First, Middle, Last)	18. Mother's Name		
	e d ta	To Be	ISSAC YEOMAN	THELM	1A	LIPPOLDT
lary	2 should and Men is marke aumatic			ing Address (Street and Number or Rural		
	1 and 2 Health tam 27 to		MICHAEL M. GALLOWAY - SON 2500 20a. Method of Disposition 20b. Place of Dispo			
nor	Pages nent of H int: If its iry or of		1 Burial 2 □ Cremation 3 □ Removal from State cemetery, cre	RANCH CEM. 1/16/		Location - City or Town, State CSTMINSTER, MD.
altimore,	구두다는			22. Name and Address of FacilityFLET		
ä	Depared Important any ir		N / 1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/	54 E. MAIN ST.,		
П			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	iter the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition resulting in death)	2011/10/20	ident	Onset and Death
	/Medical Examiner		Due to (or as a consequence of):	& beallation		
	18-11	Jer	Sequentially list out citions if any, leading to immediate cause. Enter Underlying	# 12 WILLIAM	V(
V	acuted ind transit	Examiner	Cause (Disease or injury that initiated events c.			
8760,	icate be executed physician and s the burial-transit	al Ex	Due to (or as a consequence of):			
		edical	d			
Xo	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	In/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 [□Ectopic pregnancy		23d. Date of delivery
P.O. Box	e deat he atte	Physician/M	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month Day Year
<u>Ч</u>	hat the	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I	23e Did tobaco	co use contribute to the cause of death?
ds,	uires tha signed Id be def	d by	CAO, HIN	and on the second secon	1 ☐ Yes	2 No 3 Probably 4 □Unknown
COL	s been si should	olete			24a. Was an	24b. Were autopsy findings available
Re	sician: The law s certificate has b irector, page 2 s	Completed			autopsy performed 1 Yes 2 X	prior to completion of cause of death? No 1 ☐ Yes 2 ☒No
/ita	cian: ertifica ector, I	Be	25. Was case referred to medical examiner?	26. Place of Death		
ot	ing Physician: After this certific funeral director,	٦.	1		e 5 Residence	6 Other (Specify)
on	ding F th. : After s funera	tlon	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	Work? M 1 ☐ Yes 2 ☐ No	od. Describe now i	ijury occurred
Division of Vital Records,	Attar ar dea actor by the	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 4 ☐ Homicide 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	Bf. Location (Street City or Town, St	and Number or Rural Route Number,
Ō	Hospital or Attano 24 hours after death Funaral Diractor: tely filled in by the		3,33,43,43			
		Medical	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one) (Check only one)	th occurred at the time, date and place, ar ivestigation, in my opinion, death occurred	nd due to the cause d at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
	To the within 2 To tha complet	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
)			orbansyn & cus	D 5170	5 0	1-13-2006
	1_		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	+	1-13-2006 tel mo 21157
	Ų Sta	to	M, PANSURIYA 3H9 Moulto 31. Date filed (Month, Day, Year) 32. Registra's Signature	Im DR, Wes	tmins	THE MID WILL
	Registr		JAN 1 7 2006 January M.	Rocally 1		

DHMH 17 Rev 1/2001

ORIGINAL

			For State Ragistrar		Maryland		artment rtificate					ag. No.	06	0	07	28
	Physici	an	1. Decedent's Name (First, Middle, I	•							2. Date of Dea Month	Day				
	/Medic	al	Kathleen	Hiner							January		, 20	Yeer 2006 6:15 A f Death Ltimore 9. Birthplace (State or Mary Land 10d. Inside City 1 Yes nat Country? S.A. American Indian, White, etc. White State. Zip Code) 236 City or Town, State Mary Land Homes 236 Approximate Interval Betwoonset and Death Conset	6 A M	
	Examin	er	4a. Facility Name (If not institution, g		ber)				Location o	of Death		40. (-		Death Death Limore Birthplace (State or Country) and 10d. Inside City 1 Yes : Country? A. American Indian, White, etc. White Birthplace (State or Or Country) A. American Indian, White, etc. White Birthplace (State or Or Country) A. American Indian, White, etc. White Birthplace (State or Or Country) A. American Indian, White death Approximate Interval Betwoonset and Dr. Approximate In	
Ц			4217 Darleigh		. Age (In yrs. Ia	ast hirthday	If Under		more If Under	24 Hrs. 1	8. Date of Birth					or Foreign
	Funeral		5. Social Security Number 218-07-8438	Sex 7 1 □ M 2 ☑ F	. Age (III yrs. 16	Yrs.		Days	Hours	Min.	April 2	Year)	20	Coun Mari	il and	a or roraign
	Director		Usual Residence of Decedent								10.000 2	<u> </u>		11100 00	, 000, 100	
	NOW IN		10a. State 10b. County		10c. City	, Town or L								1		
	18 - 1 st	tor	Maryland Baltim	ore			Balti	more							1 🗆 Ye	es 2 No
	or 28	ire	10e. Street and Number				10f. Zip	Code				10g. Citiz			itry?	
1	r z nours allei death with the maryland Theturel', or Items 23a or 28e-f show Wical Examinat must be notified at	Funeral Director	4217 Darleigh	Road						236						
-	lems lems	ıneı	11. Marital Status	12. Was Deced Armed Ford 1 Tyes 2	lent Ever in U.S Ses?	S. 13.	Was Deced If Yes, spec	lent of Hi afy Cuba	spanic Ori n, Mexicar	gin? (Spe n, Puerto f	cify Yes or No- Rican, etc.)	1				
9	or l	Ϋ́F	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Dat			1 🗆 Yes 2	2X No	Specify:				Specify:	Wh	ite	
	ture!	d be	15. Decedent's		185.	16a Dece	dent's Lisua	I Occupa	ation		1	16b. Kin	d of Bus	iness/Inc	dustry	
215-0036	. 3	ojet	(Specify only highest	grade completed)	45->	(Give life.	dent's Usua kind of wor DO NOT us	rk done o e retired	luring mos)	t of workir	ng				,	
212	r then	Completed by	Elementary/Secondary (0-12) 12th Grade	College (1-	401 5+)	Но	memak	er				Ou	vn Ho	ome		
	Hyg othe ent,	a)	17. Father's Name (First, Middle, La		<u> </u>						(First, Middle,		Sumame)		
<u>a</u>	Aenta Aenta rked tice	To B	Thomas Joseph	Murphy				-	V	eroni	.ca Sa	tein				
Maryland	s 1 and 2 should be liled within I Health and Mental Hygiene. Item 27 is marked other then other treumatic event, II to M		19a. Informant's Name/Relationship												Code)	
	of Health of Health Fitem 27 i		Mrs. Colleen Ale	xander (o					Road	-	utimore					
ore	iges 1 of of He or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3	□Removal from S	1210	lace of Disperent of the lace	matory`or o	ther plac			ate			1		
Ĕ.	Pag ment ent: I ury o		'4 □Donation 5 □Other (Spe		Bel				,				-		-	l
Baltimore,	permit. Pages Department of Importent: If i any injury or once.		21. Signature of Funeral Service Lie	e Rix	eken						imunek 1 Utimo u				S	
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or compose, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	aDue to (c	ich lin	CES A	serz	o or dynn	g, 3001 a3	oardiao o	тозрпаюту ап	031,			Interval E	Between
8/60,	icate be executed physician and sthe burial-transit	dical Examiner	that initiated events resulting in death) Last	cDue to (c	or as a consequ	uence of):						-				
.O. Box 6	law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		rth 2 ☐ Fetal ant at time of de	death 3	⊒Ectopic pr ⊒ Other (sp					2	3d. Date Mont		-	Year
rds, P	quires that n signed t ald be det	by	Part II. Other significant condition	s contributing to de	ath but not resu	ulting in the	underlying c	ause give	en in Part i	ł. 		bacco us es 2				of death?
Vital Records,	9 4 9	Completed											d∈	/ere auto rior to co eath? Yes	_	gs available of cause of
ita	ilclen: Th certificate rector, pay	Be (25. Was case referred to medical examiner?							e of Death	(Check only o	пе)				
oţ<	hysic nis ce I dire	To	1 Yes 2 No	Hospital: 1 🗆 Ir	npatient 2	ER/Outpatie		-	4 🗀 🛚 🖂		me 5 X Resid				y)	
0 0	ding Ph J. After th funeral		27. Manner of Death 1 ✓ Natural 5 ☐ Pending	28a. Date o (Monti	f Injury h, Day Year)	28b. Time Injury		28c. Injun Worl			28d. Describe h	ow injury	occurre	d		
\leq	l or Attendatter deatt Director:	Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place	of Injury - At ho ng, etc. <i>(Specif</i>)	ome, farm, s	M treet, factory		Yes 2□	-	28f. Location (S City or Tow			r or Rura	al Route N	umber,
	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	ledical C		Physician: To the kaminar: On the ba and mann	sis of examina											e(s)
	To the To the To the Compile Compile	Me	29b. Signature and title of certifier				290	c. Licens	e number	7		29d. Date	signed	(Month,	Day, Year	-)
)	/		1 Mass					3)1	846	8/		1/	16/	06		
6			30. Name and address of person w	ho completed cause	e of death (Item		Print)	PHIA	Ro	いかり	BACI	Me	ME		212	37
	St Benist	ate	31. Date filed (Month, Day, Year)	2005 32. R	gistrar's Signa	iture	Acres 19	8			,					

		1	For State Registrar	State of I		artment of Health rtificate of Deati	L	giene Reg. No. 006	00729
			1. Decedent's Name (First, Middle, Last)			2. Date of De. Month	ath Day Year	3. Time of Death
	Physicia /Medic		Ethel Anna Heck					14,2006	10:30 A. M
	Examin		4a. Facility Name (If not institution, give		er)	4b. City, Town, or Location		4c. County of Dea	
14	4	, .e.	Joseph Richey Hos		Age (In yrs. last birthday)	Baltimor	er 24 Hrs. 8. Date of Bird		/A rthplace (State or Foreign
	Funeral Director		5, Social Security Number 6. Se 117-12-5578	х Эм 250XF /	81 Yrs.	Months Days Hours		y, Year)	timore MD.
~	16		Usual Residence of Decedent		01		Durie 17	,172+ Dai	
	how		10a. State 10b. County		10c. City, Town or Lo	ocation			10d. Inside City Limits 11☑ Yes 2 ☐ No
	Ba-f	cto	Maryland N/A		Baltimo				
	vith th	Director	10e. Street and Number		7/06	10f. Zip Code	. 7	10g. Citizen of What C	
	s 23s	erai	524 N.Charles Str	eet Apt		2120		United - 14. Race - Am	
	Iten de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Amed Force	es?	Was Decedent of Hispanic (If Yes, specify Cuban, Mexic	can, Puerto Rican, etc.)	Black, Wh	
99	urs al	by	3 XWidowed 4 □ Divorced	If Yes, Give Year or Date		1 ☐ Yes 2 ☑ No Speci	fy:	Specify: W	hite
20	n 72 hours after death with the Maryland "naturel", or Items 23a or 28a-f ehow colcal Examinational be notified at	Completed	15. Decedent's Ed (Specify only highest grad		(Give	dent's Usual Occupation	ost of working	16b. Kind of Busines	s/Industry
21	d within giene. ir than	idu	Elementary/Secondary (0-12)	College (1-4	or 5+)	DO NOT use retired)		0	II
12	70 0		17. Father's Name (First, Middle, Last)	N/A	Ho	ome Maker	ther's Name (First, Middle,	Own Maiden Sumame)	Home
and	ed as b	o Be	Raymond Seabrease				es Walker		
Maryland 21215-0036	d 2 should the and Ment 7 is marked treumatic	2	19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Address (Street and Num		er, City or Town, State,	Zip Code)
	d 2 h a 4 h		Mrs. Mary A. Finc	h (Sist	er) 6 Mea	adow Street	Berlin, Mar	yland 218	11
J.	es 1 and of Healt fitem 2		20a. Method of Disposition		20b. Place of Disponentary cre	osition (Name of matory or other place)	Date	20c. Location - City of	r Town, State
Ē		- 83	1 ☐ Burial 2 【MCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Evans Fu	neral Chapel	Jan.16,2006	Forest Hi	11,Maryland
Baltimore,	permit. Pag Depertment Important: I any Injury o		21. Signature of Funeral Service Licen	- gar	2, h . P.	2. Name and Address of Face eaceful Alter 325 York Road	natives Fune Timonium.	ral&Cremat Marvland	ion Ctr.,P.A. 21093
-	* *		23a. Part I. Enter the disease, or composhook, or heart failure. List only	lications that cau	ised the death. Do not en	ter the mode of dying, such	as cardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	· acu	ite avoca	1 1 (/)	rction		DOLU S
	/Medical Examiner		resulting in death)	,	as a consequence of):	16011			
	Lxammer	_	Sequentially list conditions,	b. CON	as a consequence of):	artaine	(chronic)		phknown
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	·	umous				Daus
Ġ,	be executed sician and bunal-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or	as a consequence of):	,	: 1		
98760	icate be physicial s the buri	dical	(a end	stage penal	disease	(clinonic)		ChKnaun
Box 6	eath certific attending pl	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		ome of pregnancy h 2 Petal death 3	⊒Ectopic pregnancy		23d. Date of d	,
	deat	sicia	in the past 12 months? 1 □ Yes 2 🗷 No		nt at time of death 5[Other (specify)		Month	Day Year
P.0	that the de led by the a detached t	Phy	9 Unknown			underhänn zuwa awan in Oo	230 Did 1	obacco use contribute	to the cause of death?
	w requires that been signed I should be det	þ	Dementa						Probably 4 Unknown
Vital Records,	e las has	Completed	_ Cerebral u	ascular	- chetase	with CVA	24a. Was auto perfo	psy prior to ormed? death?	autopsy findings available completion of cause of
ita		Bec	25. Was case referred to medical examiner?			26. Pl	ace of Death (Check only		
of V	d is	5	1 ☐ Yes 2 No		patient 2 ER/Outpatie		Nursing Home 5 ☐ Resi		ecify) +OSDICE
n	ding P	on:	27. Manner of Death 1 Natural 5 ☐ Pending		Injury 28b. Time of Injury	Work?		how injury occurred	
Sio	Attending or death. actor: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be		f Injury - At home, farm, s	M 1 ☐ Yes 2		Street and Number or i	Aural Route Number
Division	or Attance after death Diractor:	Certification:	4 Homicide determined	building	g, etc. (Specify)	reet, factory, office	City or To		Taran Tiodio Trambon,
	To the Hospital or Attanding Ph within 24 hours after death. To the Funers! Director: After th completely filled in by the funeral	edical C	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the b niner: On the bas and manne	is of examination and/or is	th occurred at the time, date nvestigation, in my opinion, o	and place, and due to the death occurred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	To the within To the	Me	29b. Signature and title of certifier			29c. License number	er	29d. Date signed (Mo.	nth, Day, Year)
•			* Kallarine Has	ium K	W	70035	7/2	1/14/01	
	8		30. Namel and address of person who	completed cause	of death (Item 23a) (Type	Print)	N. Waws	3	110 217-1
	- W. C.	áté	31. Date filed (Month, Day, Year)	32 10	Oph U(hu)	tospice 828	N. WHaws	r. Dalto	IND ACOL
	Regist		IAN 1 7 20	006 1	M. A.	sells!			

DHMH 17 Rev 1/2001

		1	For State Registrar	State of Maryland		tment of H ificate of L			iene og. No.	5 (0730	
76.	į.		Decedent's Name (First, Middle, Last)					2. Date of Deat Month		Year	3. Time of Death	
	Physicia		Paul La	wrence Hignu	ıtt			January			6:35 A ^M	
)	/Medic Examin		4a. Facility Name (If not institution, give st			4b. City, Town, or	Location of Death		4c. County o	f Death		
			3258 Ryerson Ci	rc1e		На1е	thorpe		Ва	1tin	nore	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	9. Birthpl Count	ace (State or Foreign	7
	Director		217-52-3956	M 2□F 59	Yrs.			MAR 15,	1946	Mary	land	
5	3 2	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Loca	ation				10	od. Inside City Limits	
200	oho Mara	ō					1.1.				1 ☐ Yes 2 📉 No	
9	28a-	Director	Maryland Baltimor	е		10f. Zip Code	thorpe	1	0g. Citizen of WI	hat Coun	trv?	
4	o e			1 -			207		7.7.0	٦.٨		
4	ns 23	Funeral	3258 Ryerson Circ	LE 2. Was Decedent Ever in U.S.	13. W	as Decedent of Hi	227 spanic Origin? (Sp	ecify Yes or No-	14. Race			
a di	e de	Fun	1 ☐ Never Married 21 Married	Armed Forces? 1 ☐ Yes 2 ☑ No		_	n, Mexican, Puerto	Rican, etc.)		, White, e	etc.	
336	0,1	þ	3 Widowed 4 Divorced	If Yes, Give X Year or Dates:	. 1	Yes 2 No	Specify:		Specify:	Wł	nite	
ק אָ	atur Ical	Completed	15. Decedent's Educ (Specify only highest grade		6a. Decede	ent's Usual Occupa	ation during most of work	una	16b. Kind of Bus	iness/Ind	lustry	
215		ple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use retired)	9				
2	r th	Con	12		Tru	ck Drive			Truck			_
Ind 21215-0036	ital Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be rightlisted at	Be (17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle,	Maiden Sumame)		
aryla aryla	marked c	2	Wilson Hignutt				Bert		UNK			_
-	and ls m	0 1	19a. Informant's Name/Relationship (Typ				and Number or Ru				Code)	
	airo ealth m 27 her tu		Georgeanna L. Higm			Ryerson (Circle F	Malethorn	20c. Location - 0		wn State	
altimore,	nent of H nent of H int: If Ite		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re	moval from State cem	etery, crem	atory or other plac				•		
<u> </u>	tant:		4 □ Donation 5 □ Other (Specify)				Inc. $1/18$		Balti			_
Ball	Definit. Pages Department of Important: If Its any Injury or o		21. Signature of Funeral Service License	, let			ss of Facility Cr					
	70 = 4 Q		Fdward A Grego 23a. Part1. Enter the disease, or complic	rchik	29	9 Freder	ick Road	Baltin	ore, MD	2122	Approximate	_
			shock, or heart failure. List only on-	e cause on each line.			N 6				Interval Between Onset and Death	
100	hysician		Immediate Cause (Final disease or condition resulting in death)			ictive 1	Auway	Dise	eux		2 YEAR	
	/Medical xaminer		resulting in deality	Due to (or as a consequer		N	()			C YEARS	1
18 July 1	JAC V	L	Sequentially list conditions, b.	Due to (or as a consequen							6 70,11 0	
/ 1	nsit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (01 23 2 0011004001	.00 01/.							
	sicien and burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequen	nce of):							
8760,	icate be executed physicien and s the burial-transit	dicai E										
		a l										
Вох	Proystoten: The law fequites that the death certificate that been signed by the attending praid director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant 23	Bc. If yes, outcome of pregnance		Cata sia programa			23d. Date		•	
m	dearr e atte d for	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fetal de 4 Pregnant at time of deat		Ectopic pregnancy Other (specify)			Mon	th	Day Year	
P.O.	that the de led by the a detached t	hys	9 Unknown	9 Unknown								
· .	es tha igned be det	by P	Part II. Other significant conditions con	tributing to death but not resulti	ng in the un	derlying cause giv	en in Part I.		/		e cause of death?	
rd.	w require been sig should b	edi						1\2\Y	es 2 No	3 🗌 Prob	ably 4 □Unknown	1
Division of Vital Records,	aw re as bea 2 sho	Completed						24a. Was a autop		ere auto	psy findings available appletion of cause of	э
m i	the has	mo.						perfor	med2 d	eath? □ Yes		
ita	rtifica	0	25. Was case referred to medical				26. Place of Dea	ith (Check only or	ne)			
>	nysic lis ce direc	To B	examiner? 1 ☐ Yes 2 ▼ No	ospital: 1 ☐ Inpatient 2 ☐ EF	VOutpatient	3 □ DOA Oth	er: 4 Nursing H	lome 5 Resid	ence 6 Othe	r (Specif	()	
0	neral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	3b. Time of Injury	28c. Injur Wor	y at k?	28d. Describe h	ow injury occurre	∍d		
Si Si	Attending r death. ector: After by the fune	atic	2 ☐ Accident investigation				Yes 2 □No		··········			
ž į	r Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	eet, factory, office		28f. Location (S City or Tow	itreet and Numbe n, State)	er or Rura	I Route Number,	
Δ :	intel c			V					· · · · · · · · · · · · · · · · · · ·			
	To the Hospitel or Atending Prysicien: The within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page	Medical	(Check only 2 Medical Examin	ician: To the best of my knowledger: On the basis of examination								
	thin 2 the mplet	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	e number	T.	29d. Date signed	(Month.	Day, Year)	
	Z 3 Z 8	1	A Aller	- ~ ~							7, 2006	
	١.		J Chr LVM		2a) /T: '	(Bring)	201-1		Januar	у Г	, 2000	
	Y	1	30. Name and address of person who co	^	CE, E	BA , BA	LTIMPRE, N	1021202				
1	C.	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	(O of	•						
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State

Registrar

32. Registrar's Signature

1

2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 10:00 PM JANUARY LARA HOOD 10 2006 /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A JOHNS HOPKING BHYNEW MEDICAL CENTER BALTIMORE If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Months Hours 1 M 200 F Director 15,1918 Maryland 214-01-8779 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other then "natural", or Items 23a or 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 77 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Dundalk 1 Yes 2 No Maryland Baltimore Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Lot 72 21222 United States 3701 Old North Point Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify 3 Widowed 4 □ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth Otts ျှ Frank C. Brown 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21222 Catherine J. McCauley 3811 Pirog Drive Baltimore, Maryland 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of h Important: if ite any injury or ot otice. cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State □Donation 5 □Other (Specify) Gardens of Faith Cem. 1/14/2006 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Wise Ave. Dundalk, Maryland 21222 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PNEUMONIA 2 WEEKS /Medical Due to (or as a consequence of): Examiner ZWEEKS STROKE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed effect death. burial-transit attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ ate has been signipage 2 should be STROKE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? SEIZURES 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 **X**No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ٥ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: 28c. Injury at Work? 1 XNatural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident efter death Director: the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 - Homicide within 24 hours e To the Funeral C 29a. Certifier 1 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

10

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

Christina

31. Date filed (Month, Day, Year)

Hines, MD

32. Registrar's Signature

P19626

4940 Eastern Ave.

Johns Hopkins Bayview Medical Ctr.

JANUARY 10, 2006

Baltimore, MD

				For State Registrar		State o	of Mar	ryland .		artmen <i>tificate</i>				ental Hy	/gien Reg. N	/ 11 11	6	00733	
		Physicia	an	Decedent's Name (First, Michael Control of the	ldle, Last)	Laura	Bel	le Ho	bel					2. Date of De Month Januar	Da		rear	3. Time of Death 6:00 A M	
	1	/Medic Examin		4a. Facility Name (If not institu	ion, give s					4b. City,	Town, or	Location of		Januar		c. County o		6:00 A	_
		LAGITITI	.C.I	Stella Maris	Hosp	pice C	tr.			Ti	moun	ium				Bal	timo	ore Co.	
AM		Funeral Director		5. Social Security Number 283-18-2287	6. Sex 1□	м 272 F	7. Age ((In yrs. last	t birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D July	irth ay, Year 14,1	919	9. Birthp Co <i>un</i> Kent	lace (State or Foreign try) cucky	
20		pu &		Usual Residence of Decedent 10a. State 10b. Cour	ntv.			10c. City, T	Town or Lo	cation							1	0d. Inside City Limits	
00:9		Aanyla	ō					roo. Oity, i	OWN OF EG	oation			D	J - J J-			'	1 ☐ Yes 2½ No	
		the A	Director	Maryland 10e. Street and Number	ватт	imore				10f. Zip	Code		Dune	laik	10g. C	itizen of Wi	nat Coun	itry?	
-0		3a or		3417 Courtw	av							2122	22			Unite		•	
0		death	Funeral	11. Marital Status	1	2. Was Dec		er in U.S.	13.	Was Deced	ent of Hi	ispanic Ori	igin? (Spec	offy Yes or N lican, etc.)	0-	14. Race	Americ White,		_
30	215-0036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Pygleine. Important: if Item 27 is marked other than "natural", or Iteme 23a or 28a-f ehow supprintury or other treumatic event, Ite Medical Explicational and once.	by	1 Never Married 2 N	1	1 Yes If Yes, Gi Year or D	2 □XNo ive)		1 🗆 Yes		Specify:		iouri, oto.,		Specify:		nite	
	Š Q	72 ho	Completed	15. Decec (Specify only hig	lent's Educ	cation		1	16a. Deced	dent's Usua kind of wor	I Occupa	ation	t of workin	a	16b.	Kind of Bus	ness/Ind	dustry	
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	2	led w tygier her th		10 Years 17. Father's Name (First, Midd	lo (act)				I	Homem	aker		or's Namo	(First, Middle	Maido	Own H			_
2	Maryland	uld be the dental F rked ot tic ever	To Be	Robert E.		ell						to. Would		ary Bu		in Sumam o	,		
ra	Mary	12 sho h and h 7 is ma treuma		19a. Informant's Name/Relation Juanita McSor		oe, Print) (Sis	ter)			-				Route Numb	-			Code) 17356	
	re, I	of Healt		20a. Method of Disposition		•		20b. Plac	e of Dispo	sition (Nan	ne of			ate	,	Location - C		wn, State	
Ja.	Baltimore,	t. Pege rtment c rtant: If sjury or		1 ⊠ Burial 2 ☐ Crematic 4 ☐ Donation 5 ☐ Other	(Specify)	_	State	Garde	ns of	f Fai	th C	em. 1						Maryland	
ĺ	Ba	Departiment Department		21. Signature of Fund Sirv	in Lion	2	2/6	ran	Di	ida-Ri 122 Wi	d Addres JCK LSE <i>I</i>	Funer Ave.	al Ho	ome of lalk, N	Dur Mary	dalk, land	Inc 212	22	
	1			23a. Part1. Enter the disease shock, or heart failure.	or complic ist only on	e cause on	each line	١.						respiratory	arrest,			Approximate Interval Between Onset and Death	
		Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	Due to	_	consequen		CAN	ICC	ER							
	H	Examiner	-e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ь		(or as a	consequen	nce of):										
	d	cuted nd ransit	Examiner	that initiated events	【。			•											
	8760,	cate be executed physicien and the burial-transit	ai Ex	resulting in death) Last	l.	Due to	(or as a	consequen	nce of):										
	687	phy phy the	edicai		d	•													
	Вох	eath certifi ettending for use as	M/UR	IF FEMALE: 23b. Was decedent pregnant	23	3c. If yes, ou		f pregnancy		DEctopic pr	ecnancy					23d. Date		•	
	P.O. B	The law requires that the death certif ate hes been signed by the ettending page 2 should be detached for use a	by Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			nant at ti	me of deat		Other (sp						Mont	n	Day Year	
12/	<u>s</u> ,	res that igned b be deta	by Pi	Part II. Other significant cond	itions con	tributing to c	death but	not resultir	ng in the u	nderlying c	ause give	en in Part I	l.					ne cause of death?	
AUR	corc	w requi	ieted	9										24a. Wa				psy findings available	_
17	Vital Records,	ysician: The lav is certificate hes director, page 2 a	Completed											auto perf 1 ☐ Yes	opsy formed? 2 N	Dr	or to cor ath?] Yes	mpletion of cause of	
1	Vita Vita	ician: Th certificate rector, pag	Be	25. Was case referred to med examiner?		ospital:					Oth	0.00		(Check only		921		11 ,	
- 1		Attending Physician: r death. sctor: After this certification the funeral director.	n: To	1 Yes 2 No 27. Manner of Death		28a. Date	Inpatient of Injury	28	VOutpatier		8c. Injury Work	4 (1)		ne 5 🗌 Res 8d. Describe				Hospice	1
8	<u>o</u>	ath. rr: Aft	atio	E C / Nooidoint	stigation	(MOI	nth, Day	rear)	Injury	М	1 🗆 ,	Yes 2	No						
40	Division of	l or Atterde afterde Directo	Certification:		uld not be ermined	28e. Plac build	e of Injur ling, etc.	y - At home (Specify)	e, farm, str	eet, factory	, office		2	8f. Location City or To			or Rura	l Route Number,	
	_	To the Hospital or Attending Phymin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral.	edical C	29a. Certifier 1 Certi (Check only 2 Medione)	ying Phys	ner: On the t	e best of basis of e	examination	edge, deatl	h occurred vestigation	at the tim , in my of	ne, date ar pinion, dea	nd place, a ath occurre	nd due to the d at the time	e cause(e, date ar	s) and man nd place, ar	ner as st ad due to	ated. the cause(s)	-
		o the o the omple	Mec	29b. Signature and title of cer	ifier	and mar	"ioi statt			290	. License	e number			29d. D	ate signed	(Month,	Day, Year)	_
		- s + ō			11.	-					D'	437	125		Ja	inua	14	14,2000	6
		5		30. Name and address of pers	on who co		ise of dea	ath (Item 2:	За) (Туре,	Print)	30	OD	ULA	NEY	VA	LLE	1/	14,2006 20AD 193	
	72	Sta Registi		31. Date filed (Month, Day, Ye			Registrar	's Signatur	е	e (11) C	, N) [a iri		71246	MN	υ	XIU	7.5	

			State Registrar	State of Marylan		artment of F			200	6 (00734
	Physici /Medic		1. Decedent's Name (First, Middle, Last) MARY ISABELE HA	SLBECK				2. Date of Dea Month JANUARY	Day	Year OO6	3. Time of Death 9:30 a.
	Examir		4a. Facility Name (If not institution, give st STELLA MARIS NURS 5. Social Security Number 6. Sex	reet and number)	last birthday)	TIMO	r Location of Death	8 Date of Birth	Pag. No. Bath Day Ye Y 14, 2006 4c. County of D BALT Th ay, Year) 10g. Citizen of What USA O- 14. Race - A Black, Specify: I 16b. Kind of Busine TEXTIL D, Maiden Sumame) COCKEYSV SON FUNERAL SON, MD 212 arrest, 23d. Date of Month tobacco use contribut tobacco use contribut tobacco use contribut tobacco use contribut Yes 2 No 3 C arrest, 23d. Date of Month tobacco use contribut tobacco use contribut tobacco use contribut contribut yes 2 No 3 C arrest, 23d. Date of Month Callse(s) and manner Core of County of County County of County County of County Coun	ty of Death	RE
	Director			w 2X□F 89	Yrs.	Months Days	Hours Min.	(Month, Day) 09/15/	1916	MAR	place (State or Foreigntry) YLAND
	he Marylan 28a-f show culling at	ector	MD BALTIMOR 10e. Street and Number		y, Town or Lo	TIMONI	UM				10d. Inside City Limit 1 ☐ Yes 2 🔀 N
	h with t	al Dir	2300 DULANEY VALLI	EY RD.		10f. Zip Code 210	93	1	_		atry?
5-0036	parmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Itams 23e or 28e-f show any figury or other traumatic avent, the Madical Evaluation must be notified at once.	by Funeral Director	11. Marital Status 1. 1 ↑ Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2∑ No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Ra BI		etc.
21215-0	d within 72 ho giene. er then "netu	Completed	15. Decedent's Educ. (Specify only highest grade Elementary/Secondary (0-12) 12th GRADE	ation completed) College (1-4or 5+)	(Give life. L	dent's Usual Occup kind of work done OO NOT use retired	during most of wor	king			dustry
Maryland 2121	should be filed nd Mental Hygid marked other amatic avent, II	To Be C	17. Father's Name (First, Middle, Last) GEORGE HASLBECK					ne (First, Middle, I E POTTER			
	and 2 sho salth and h n 27 is ma		19a. Informant's Name/Relationship (Typ HELEN MCGUIRE/SIS			-					
altimore,	Pages 1 at the thent of He tent: If item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re `4 ☐ Donation 5 ☐ Other (Specify)	moval from State DUL	ANEY V	sition (Name of natory or other place ALLEY ME)	M. 01/1				
Ba	parmit. Depart Import any inj		21. Signature of Funeral Service Licenses	Haije	85	Name and Addre	RAVEN BLV	D. TOWSO	N, MD		ó
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cause on each line. Due to (or as a consequence)	· firm			e or respiratory arre			Approximate Interval Between Onset and Death
8760,	cate be axecuted obtysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consequence to (or as a consequence)							
P.O. Box 6	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	Ideath 3	Ectopic pregnancy	,				ery Day Year
ords, P	w requires that been signad b should be deta	by	Part II. Other significant conditions cont	ributing to death but not resi	ulting in the ur	nderlying cause giv	en in Part I	><			/
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Division of Vital Records,	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	n: To Be	27. Manner of Death	spital: 1 Inpatient 2 Inpatient 2 (Month, Day Year)	ER/Outpatien		er: 4 Nursing H		nce 6 Ot		γ)
ivisior	l or Attendin after death. Director: Aft I in by the fur	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		M 1 🗆	Yes 2 □ No	28f. Location (St. City or Town		iber or Rura	I Route Number,
	To the Hospitel or A within 24 hours after To the Funerel Direct completely filled in by	edical Ce	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examino	cian: To the best of my kno er: On the basis of examinal and manner stated.	wledge, death tion and/or inv	occurred at the time	ne, date and place pinion, death occu	, and due to the ca	ause(s) and mate and place	nanner as st	lated. the cause(s)
)	To the within 3 To the comple	Med	29b. Signature and title of certifier			29c. Licens	e number	2:	9d. Date sign	ed (Month,	Day, Year)
	le		30. Name and address of person who con	npleted cause of death (Item	23a) Type,	Print) Robert	L. Moss	MD ,	MI	21.	136
DH	Sta Registi	rar	31. Date filed (Month, Day, Year) JAN 1 7 200	32. Agistrar's Signa		and .					

			1- State of Maryland / Dep Registrar Ce	artment of Health a		2000	00735
	Discrete!		Decedent's Name (First, Middle, Last)		2. Date of De Month	ath	3. Time of Death
	Physicia /Medic		Earl Lance Hodges, Sr.		January	y 15, 2006	12:00 A ^M
	Examin	er	4e. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of	of Death	Reg. No. Death Ty 15, 2006 County of Death Baltimore	
			Ivy Hall Geriatric Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	Middle River	24 Hre 0 D (D)		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 218–12–3028 7. Age (In yrs. last birthday, 83 7. Age (In yrs. last birthday, 83 7. Age (In yrs. last birthday, 83 83 83 83 83 83 83 83 83 83 83 83 83	Months Days Hours	Min. (Month, Da	v. Year) Con	untry)
7			Usuel Residence of Decedent		rep. o	,1922 VIIC	шиа
	how		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Be-f s	cto	Maryland Baltimore Dundalk				1 ☐ Yes 2x ZvNo
	with the	Dire	100. Street and Number	10f. Zip Code			untry?
	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. ad other then "naturel", or items 23a or 28e-f show other then "naturel", or items 23a or 28e-f show event, the Madical Examiner natal be notified at	Funeral Director	1902 Ormand Road 11. Marital Status 12. Was Decedent Ever in U.S. 13.	21222 Was Decedent of Hispanic Ori	igin? (Specify Vec or No		ion Indian
^	r iten	Ξ	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	If Yes, specify Cuban, Mexican	n, Puerto Rican, etc.)		
200	within 72 hours after ene. then "naturel", or ite he Medical Extrivitu	ρ	3 ₩idowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes > ☐ No Specify:		Specify: Wh	ite
2	72 ho	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation	st of working	16b. Kind of Business/I	ndustry
7	within ne. hen	Id m	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	,	m1	
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and	id be ental ked o	To Be	Doc Jackson Hodges		ie Florence		
a S	2 should be and Mental Is marked of eumatic ev	-	19a. Informant's Name/Relationship (Type, Print) 19b. Maili				
, Mai	and 2 salth a n 27 I				Road, Notti	ngham, Maryl	and 21236
e e	ges 1 t of He If iter		LABURAL 2 Cremation 3 Removal from State	matory or other place)	Date		
Баппто	t. Pag tment tent:					•	_
a D	permit. Pages 1 and 2 should by Department of Health and Menta Importent: If item 27 is marked any injury or other treumatic ev		21-Signature of Funeral Service Licenses 2	2. Name and Address of Facili Bruzdzi 1407 Old Easte	inski Funera ern Avenue,	al Home, P.A Essex, Mary	1. vland 21221
			23a. Part 1. Safer the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.				Approximate Interval Between
١	Physician		Immediate Cause (Final disease or condition	Dechne			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):				
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ŗ.	w requires that the di been signed by the should be detached	y Ph	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	. 23e. Did t	obacco use contribute to	the cause of death?
ecords,	quires n sigr uld be	d by	Aprilal thrombus		10	Yes 2 □ No 3 □ Pro	bably 4 Honknown
ပ္တ	≥ 0 0	plete	Dementia		24a. Was	an 24b. Were aut	opsy findings available
r	iclen: The lav certificate has rector, page 2	Completed			perfo	rmed? / death?	
VITA	shriffica ctor, I	Bec	25. Was case reterred to medical examiner?	26. Place	e of Death (Check only o		
	hysic this co	၉	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie				ify)
Ĕ	Attending Physiclen: r death. ector: After this certific: by the funeral director,	lon	27. Manner of Death 1 Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?		how injury occurred	
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	thin 2 the of the	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Month)	
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	h		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)			
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DHMH 17 Rev 1/2001

			For	State of Marylar			Mental Hygier	Ponc	00736
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	Physici	an	Decedent's Name (First, Middle, La.	st)				Day Year	3. Time of Death
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	or 28s	Jirec	10e. Street and Number	12 - 1	10f.	Zip Code	10g.	Citizen of What Cou	untry?
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	item item	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces? 1 Tyes 2 XNo		cedent of Hispanic Origin? (pecify Cuban, Mexican, Pue	Specify Yes or No- no Rican, etc.)	14. Race - Amer Black, White	
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Maryland	2 should and Men is marke		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Addre	ess (Street and Number or F	Bural Route Number, Cit		
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0 0	ding Ph h. After th funeral		27. Manner of Death 1 Satural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how in	jury occurred	
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	the H nin 24 the Fi	Aedicai	one)	miner: On the basis of examina and manner stated.	ation and/or investigati	on, in my opinion, death occ	surred at the time, date a	nd place, and due	to the cause(s)
\	To To com	Σ	29b. Signature and the of certifier		2	29c. License number		Date signed (Month	
,	4		20 Name and address	M.D.	- 02-) (7 - 5 - 7	P19825	Ja	mary 11	9006
0			30. Name and address of person tho	completed cause of death (Item		. Baltmore		•	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature		ויט משטו		
	Regist	ar	JAN 1 7 2008) AND SOLD AS	A STATE OF THE PARTY OF THE PAR				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 223PM 2006 Jones January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Mary land Medical Centr 6. Sey 7. Age (In yrs. last birthday) Baltmore NIA 0) 5. Social Security Number 1 2/4-64-2624 If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Hours Days Min. 1 ☐ M 2 🛛 F Yrs. **Director** .05,195 Usuat Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Manyland ment of Heatilth and Mental Hyglene.
ant: if item 27 ie marked other then "netural", or items 23a or 28a-f ehow urt; or other teumatic event, the Medical Examinar manking multiliakt at ury or other treumatic event, the Medical Examinar manking multiliakt at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Funeral Director MARYLAND 10e. Street and Number 10g. Citizen of What Country? 3612 AVENUE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗖 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SPECIALIST VRS. FT. MEADE (U.S. GOV 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) OWLING 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTIHORE EVA DOWLING WALTERS (MOTHER) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: if any injury or once. CEMETERY 4 □ Donation 5 □ Other (Specify) 1-19-06 22. Name and Address of Fully BROWN JR, FUNERAL HOME 3140 N. FULTON AVE. BALTO, MD. 2121 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Artery Disease ovonany /Medical Due to (or as a consequence of): Examiner Peripheral Vascular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospitel or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760 Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 🗌 Probably 4 Unknown 24a. Wasan 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform ormed? 2 A No 1 Yes 1 🗆 Yes 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. D te of Injury (Month, Day Year) 27. Manner of Jeath 28b. Time of Intury 28d. Describe how injury occurred **Division** 1 Natural 2 Accident 5 Pending investigation Japiter 4 hours after dea... 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide

State Registrar

29a. Certifier

29b. Signature and title of certifies

31. Date filed (Month, Day, Year)

LOC

Mena

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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7 2006

Medical

South

22

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

00060292

Greene Street

29d. Date signed (Month, Day, Year)

January 13, 2006

Balto, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** DOROTHY JOHNSON 13:04 M 2006 JANUARY 12 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Under 1 Year | If Under 24 Hrs. THE JOHNS HOPKINS HOSPITAL If Under 1 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 M 2 F Hours 217-40-6538 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show item 27 is marked other than "natural", or items 23£ or 28e-f show other traumatic event. The Medical Examinating Item Addition 1 Yes 2 No by Funeral Director 10e. Street and Number 10g. Citizen of What Country? 00 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Be Completed 15. Decedent's Education fy only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working title DO NOT use retired) 16b. Kind of Business/Industry d Hygiene. y/Secondary (0-12) College (1-4or 5+) lame (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) if item 27 is marked o Pages 1 and 2 should be 19a. Informant's Name/Relationship (Type 19b. Mailing Address (Street and Number or Rural Route Number, 20b. Place of Disposition (Name of cametery, crematory or other p isposition 2 Cremation 3 Removal from State perriit. Page Department o Important: If any injury or ö Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee un 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SYSTEM ORGAN FAILURE 6 HOUR MULTI /Medical Due to (or as a consequence of) Examiner PSIC Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of death certificate be executed burial-transit Due to (or as a consequence of). physician Be Completed by Physician/Medical the as IF FEMALE: for use a 23c. If yes, outcome of pregnancy
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1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 ☐ Yes 2 X No 1 Ninpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending 1 XNatural death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number. City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide within 24 hours a To the Funeral L to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) -000 JANUARY 12, 2006 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21287 PO BOX 110 TOWER, GOO NORTH WOLFE STREET, BALTIMORE MARYLAND ERICS WEISS m.D 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

7 2006

		,	1- For State of Maryland / Department of Health and Certificate of Death	Mental Hyg	9	00739
			Decedent's Name (First, Middle, Last)	2. Date of Dea	th	3. Time of Death
	Physicia		Aldean Pearl Jacobs	Month 1-13-	Day Year ~2006	10:35p M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Der		4c. County of De	
		•	Millenium Health Care & Rehabilitation Glen Burnie		Anne A	runde1
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hi		(Year) 9. B	irthplace (State or Foreign Country)
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ું. 	and 3 salth n 27 ner tr		Mrs. Jacqueline Knipple/daughter 206 Summit Ave.; Gle		MD 21060	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Menlat Hygiene. Depertment of Health and Menlat Hygiene. Depertment of Health and Menlat Hygiene. Depertment of Health and Menlat Hygiene. Depertment of Health and Menlat Hygiene. Depertment of the real Hygiene. Depertment of the Hygiene.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City of	or Town, State
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rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 ☐ Yes 2 TNo If Yes, Give Year or Dates:		1 🗌 Yes	2√ No Specif	fy:			Specify:	wh.	ite	
s hou	ed	15. Decedent's E		16a. Dece	dent's Us	ual Occupation			16b. K	and of Bus			
7 nin 7.	Completed	(Specify only highest grant Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	(Give	kind of w DO NOT	ork done during m use retired)	ost of worki	ng				,	
d with	Ę			ado	pti	on_work	er		ado	ptic	n a	gency	Y
al Hy Tothe	Be (17. Father's Name (First, Middle, Last)		_			(First, Middle)		
yid build b Ment Ment arkec	<u>P</u>	Zane Roberts				Do	rothy	y C. E	Benn	ett			
2 sho and ls m		19a. Informant's Name/Relationship (**		-	ss (Street and Num							
and and mark		Dorothy C. Rob				idge Rd		ykesvi Date					
Pages 1 nent of H ant: If ite		20a. Method of Disposition 1 Deurial 2 Tremation 3 D	Tuestional italii State	Place of Dispo cemetery, crei						ocation - C			
rmit. Pages spartment of portent: If it		'4 □Donation 5 □ Other (Special		l Cour	_	,		-06					
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23e or 28e-f show any injury or other treumatic event, the Maddel Exa. Ill ref., ust be notified a	Sid	21. Signature of Funeral Service Lice Porac Hought				and Address of Fac Box 19							Chape
Physician /Medica Examine	i	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consec	sis			as cardiac c	er respiratory a	rrest,			Approximat Interval Bet Onset and	tween
of ou, cate be executed ohysician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect Due to (or as a consect d.	quence of):				-					
LIVISION OF VITAL RECORDS, P.O. BOX 00/00, To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi		23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	al death 3]Ectopic] Other (s	pregnancy specify)				23d. Date Mont		,	Year
hecords, r. he law requires that is shas been signed by ge 2 should be deta			contributing to death but not res	sulting in the u	nderlying	cause given in Par	rt I.		tobacco Yes 2		oute to th	e cause of cably 4	death? Unknown
w requestions	lete	MUITIPIE	SCLEROSIS					24a. Was	an	24h W	ere autor	nev findings	available
The lay	Completed by	700711822)				auto		l de	ath?	sy findings apletion of a 2 No	ause of
VII.al icien: T certificat ector, p	Be		Hospital:				ce of Death	(Check only	one)				
Phys Phys rthis ral dir	2	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Simpatient 2L	ER/Outpatier 28b. Time o				me 5 ☐ Resi 28d. Describe)	
Jing I	lon:	_	28a. Date of Injury (Month, Day Year)	Injury	м	28c. Injury at Work? 1 ☐ Yes 2	i	zed. Describe	now inju	iry occurre	a		
INISION I or Attending after death. Director: After in by the fune	Certificatio	2 Accident investigation 3 Suicide 6 Could not to 4 Homicide determined	De Place of Injury At h	iome, farm, sti fy)				28f. Location (City or To			r or Rural	Route Nun	nber,
lospitel hours a unerel D	edical Ce	29a. Certifier 1 Certifying P	hysicien: To the best of my kn miner: On the basis of examin	owledge, deat	h occurre	d at the time, date	and place,	and due to the	cause(s	and man	ner as sta	ated.	e)
the Hain 24 the F	edi		and manner stated.				_	-3 00 0000					"
To To	Σ	29b. Signature and title of certifier	-ft .	(2)	2	9c. License numbe				ite signed			000
L		1	ou,						JAN	JUAR	1 1	2 2	.006
6			1042 JATI920	OLD (000	IT ROAD			STO	WN	M	SA	1133
Regi	State strar	31. Date filed (Month, Pay, Year)	2006 32. Figistrar's Sign	ature	best								

DHMH 17 Rev 1/2001

Donald J. Jorio 06-0367 AKG

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a.27,28a f.2/2/06 IT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2006 January 14, DONALD JAMES JORIO 2:26 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 23 Carroll Plaza Westminster Carroll Il Under 1 Year | Il Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1**X**]M 2□ F 213-68-0008 52 Yrs Director 6/9/1953 MARYLAND Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28e-f ehow 1 XYes 2 No WESTMINSTER Director MD CARROLL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö the Medical Examiner must be 21157 USA 238 GREEN ST. 20 E. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married ŏ 1 ☐ Yes 2 No Specify Specify: WHITE þ 3 ☐ Widowed 4 X Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) AUTO REPAIR Body & Fender Man 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 end 2 should be and Mental ELBERT J. JORIO ISABELLE S. BENNETT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Item 27 is other tra JENNIFER L. CATANIA-DAUGHTER 56 WEBSTER ST., WESTMINSTER, MD. 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: if ite any injury or ot ance. 1 Burial 2 Cremation 3 Removal from State MORELAND MEM. PARK 1/18/06 BALTIMORE, MD. 4 ☐ Donation 5 ☐ Other (Specify) Fignature of Funeral Persice Licenses 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Atherosclerotic Cardiovascular Disease complicated by Hypothermia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine physicien and the burial-transit To the Hospital or Attending Physician: The law requires thet the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2X No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2□ No 24a. Was an cete hes t page 2 s autopsy performed? Yes 2□No Be 25. Was case referred to medical examiner? 26. Place of Death / Check only one. Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other 4 Nursing Home 5 Residence Other (Specify) at Scene 1 XYes 2 No Certification: To After this funeral c 28a. Date of Injury Fnd | 28b. Time of Fnd | 28c. Injury at | Work? 28d. Describe how injury occurred Subject living 27. Manner of Death 1 Natural
2 Accident 5 Pending 1 Yes 2 No 2?22 P death. 1/14/06 investigation after death | Director: / d in by the f in unheated shed 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 22 Carroll Plaza Westminster, Carroll County, MD 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide within 24 hours aft To the Funeral Di completely filled in Found: in shed behind gas station Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 15, 2006 30. Name and address of person who completed ause of death (Item 23a) (Type, Print)

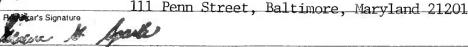
Registrar

State

31. Date filed (Month, Day, Year)

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12.



			1 - For State Registrar	State of N	Maryland / D			of Health a of Death	and Me		iene	06	00742
	Dhusisi		1. Decedent's Name (First, Middle,	Last)					2	2. Date of Deat Month	h Day	Year	3. Time of Death
	Physici /Medic	-	Juanita <u>Hil</u>	da Kyte					J	anuary	10, 2		10:44P M
	Examin		4a. Facility Name (If not institution,	give street and number	or)		4b. City, To	wn, or Location of	of Death	•	4c. County	of Death	
			Anne Arundal Med				Annap		24 Hzg		Anne		
	Funeral		, , , , , , , , , , , , , , , , , , , ,	i. Sex 7. / 1 ☐ M 2¥2¥F	Age (In yrs. last birt	Yrs.		ear If Under ays Hours	Min.	B. Date of Birth (Month, Day,			place (State or Foreign ntry)
3	Director		216-22-1002 Usual Residence of Decedent		78				J	une 22,	, 1927	West	t Virginia
	/land		10a. State 10b. County		10c. City, Town	or Loc	ation						10d. Inside City Limits
	Man Han	tor	Maryland Anne An	undel	Chur	cht	on						1 TYes 2 □ No
	h the	Directo	10e. Street and Number				10f. Zip Co	ode		1	0g. Citizen of	What Cou	ntry?
	th wit		5607 West Carve	l Dr.			2073	3			II.	S.A.	
	dea G	Funeral	11. Marital Status	12. Was Deceder Armed Force		13. W	/as Deceden Yes, specify	t of Hispanic Ori Cuban, Mexicar	gin? (Spec	ify Yes or No- ican, etc.)	14. Ra		can Indian,
9	or it		1 Never Married 2 Married	If Yes, Give		1	☐Yes 2█				Specif	fv-	
ğ	filed within 72 hours after death with the Maryland Hygiene. Hysiene. Insture!; or iteme 23e or 28e-f show ent, the Madical Examinar must be notified at	d by	3 ₩Widowed 4 Divorced	Year or Dates		Person	111-					whit	
<u>.</u>	n 72	Completed	15. Decedent's (Specify only highest	grade completed)		(Give k	ent's Usual C kind of work o O NOT use i	tone durina mos	t of working	g	16b. Kind of B	usiness/in	idustry
77	withi then	III.	Elementary/Secondary (0-12) 12	College (1-4c			maker				Domes	tio	
0	filed Hygi other	BeC	17. Father's Name (First, Middle, La	ist)	111	Onte	maker	18. Mothe	r's Name ((First, Middle, M			
lan	should be filed within 72 hours after death with the Marylan to Memial Hygiene. Tarked other then "neture!", or fleme 23a or 28a-1 ehow marked other then "neture!", or fleme 23a or 28a-1 ehow marked other then "neture!" at most the notified at	To B	William Ga	allaher				Т	accia	Gorder	,		
ar Z	2 should and Men le marke sumatic	-	19a. Informant's Name/Relationship		19b.	Mailing	g Address (S	treet and Number				State, Zip	Code)
Baltimore, Maryland 21215-0036	is 1 and 2 should of Health and Mer frem 27 le marke other traumatic		Nita Pluebell-da	ighter	56	07	W. Car	vel Dr.	Chur	chton.	MD 207	33	
or C			20a. Method of Disposition	•	20b. Place of	Dispos y, crem	ation (Name atory or other	of r place)	Da		20c. Location		own, State
Ĕ	permit. Pages Department of I Important: If its any Injury or o		1 ☐ Burial 2 ☒ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe					ematory	1/13	/2006 E	Brentwo	od, M	ÍD .
a	ppartr poort y Inj		21. Signature of Funeral Service D	cense /	Ť.	22.	Name and A	ddress of Facilit	y Fort	Lincol	n Fune	ral F	lome
D	907 2 2		Slan T.	Melo				densbur				D 207	722
			23a. Fart. Enter the disease, or co	profications that cause by one cause on each	sed the death. Do n I line.	not ente	r the mode o	f dying, such as	cardiac or	respiratory arre	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	_a Sever	e Acia	los	<i>i</i>)						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	as a consequence of	of):	1-1						
		<u>.</u>	Sequentially list conditions,	b. Mesp	ratmy	200	a./u	E					
/	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dus to (b)	as a conseque - e c	517.							
	al-tra	xar	that initiated events resulting in death) Last	c. Due to (or a	as a consequence o	of):						-	
8760	certificate be executed rding physicien and use as the burial-transit	dicai E		ď									
89		edic		<u> </u>									
Вох	leath certifica attending ph I for use as ti	M/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne of pregnancy 2 Fetal death	2 🗀	Estacia acon				23d. Da	ite of delive	ery
	0 0 0	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑ No		at time of death		Ectopic pregi Other (speci				Me	onth	Day Year
o.	at the de by the a	hys	9 ☐ Unknown							_			
ś	The law requires that the te has been signed by th rage 2 should be detache	by	Part II. Other significant condition	s contributing to death	but not resulting in	the un	derlying caus	e given in Part I					he cause of death?
pic	w requir been si should	ted	End) hoge	Kend	1se		0			1 🗆 Ye	s 2 No	3, Prot	pably 4 dinknown
Vital Records,	law rias be	Completed								24a. Was a	y	prior to co	ppsy findings available impletion of cause of
		Con								perform		death?	2 No
113	aician: Th certificate irector, pag	Be	25. Was case referred to medical examiner?	140				1 -	of Death	(Check only on	е)		
	Phys this aldi	5	1 Yes 2 No 27. Manner of Death	Hospital:						e 5 Reside			(y)
Division of	ding P h. After funer	io	1 ☐Natural 5 ☐ Pending			ime of njury	M 28c.	Injury at Work? 1 ☐ Yes 2 ☐		3d. Describe ho	w injury occui	rea	
<u>S</u>	or Attendii after death. Director: A in by the fu	icat	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	t be One Blees of	Injury - At home, far	rm etro				Rf Location (St	reet and Num	her or Rurs	al Route Number,
<u>></u>	lor A after Dire	Certification:	4 Homicide determin	building,	etc. (Specity)	, 5110	ot, raciory, c	11100		City or Towr		J G	ar riodio riginioci,
	e Hospital or 124 hours afte E Funeral Dire letely filled in I		29a. Certifier Certifying	Physician: To the be	st of my knowledge	, death	occurred at 1	he time, date an	d place, ar	nd due to the ca	ause(s) and m	anner as s	tated.
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	(Check only 2 Medical E)	taminer: On the basis and manner	of examination and	d/or inve	estigation, in	my opinion, dea	th occurred	d at the time, da	ate and place,	and due to	the cause(s)
	To the I within 2 To the I complet	Me	29b. Signature and title of certifier	. ^				icense number			9d. Date signe	ed (Month,	Day, Year)
			1/2 6	\mathcal{N}	m	0	10	00 56	735		Jan	11	2006
	11		30. Name and address of person w	no completed cause o	f death (Item 23a) (Type, P	rint)	releans			1.		
			I'm Woons		med il	ca/	f s	releases	1 1	trut	2/1/1	no	21401
3	Sta Registi		31. Date filed (Month, Day, Year) JAN 1 7 2001		strar's Signature	de	,	•					

		1	For State Registrar		State of	Maryland		artmen rtificate			and M		log. No. U U	6	00743
	Physicia		1. Decedent's Name		Last)		T/T	ist				2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al -	Elizabetl		give street and numb	ber)	KV		Town, or	Location	of Death	January	14, 20 4c. County		2:05 P M
*	Examin	Ç1	Eastpoint Re					Du	ında]	Lk			Balt		
v Sk.	Funeral Director		5. Social Security Nu 214–14–85	00	5. Sex 7 1 □ M 2 💢 F	. Age (In yrs. ia:		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day February	77,1918		place (State or Foreign ntry) yland
	land ow	-	Usual Residence of D 10a. State	10b. County		10c. City,	Town or L	ocation							10d. Inside City Limits
	ith with the Marylan 23a or 28a-1 show	ctor	MD	Baltin	ore	Du	ndalk								1 ☐ Yes 2X No
	vith the	Director	10e. Street and Num					10f. Zip	Code 2122	2			10g. Citizen of V USA	What Cou	ntry?
	eath v	erai	7416 Waym	outh wa		lent Ever in U.S	. 13.				igin? (Sp	ecity Yes or No-		e - Ameri	can Indian,
36	filed within 72 hours after death with the Maryland Hygiene. kther than "natural", or Items 23e or 28e-f show int, Ite Medical Examilian, unt be ricitling at	by Funerai	1 Never Marrie		Armed Ford	es? X No		If Yes, spec		n, Mexicar Specify:		ecify Yes or No- Rican, etc.)		ok, White, /: Whi	
21215-0036	72 hou natura	Completed	(Specif	15. Decedent's y only highest	Education grade completed)		(Give	dent's Usua kind of wo	rk done d	during mos	t of work	ing	16b. Kind of B	usiness/Ir	ndustry
121	d within giene. ir than "	mpi	Elementary/Secon	dary (0-12)	College (1-	4or 5+)	life.	House					Own Ho	ome	
		Be Co	12 years 17. Father's Name (F	First, Middle, L	ast)			HOUSE	WILC		er's Nam	e (First, Middle,			
ylan	Q 22 Q 0	To B	Frank L.	Seay								a A. Ber			
Maryland	and and and and and and and and and and		19a. Informant's Nar Richard K		p (Type, Print) Husb	and		-				a <i>l Route Numb</i> e ndalk, MD			o Code)
	s 1 and 2 of Health Item 27 I other tre		20a. Method of Dispo	osition		20b. Pla		osition (Nar matory or o		-\ \		Date	20c. Location -		own, State
Baltimore,	Pages ment of h tant: If Ite		4 Donation	5 ☐ Other (Sp			iew (remat	ory	1	17, :	20 0 6 E	altimor		
Bait	permit. Pages 1 Department of H Important: If Ite any injury or ot 2002.		21. Signature of Form	mu C	Conn	eller						ome Of I Road, I		P.A. MD.	21222
760, 🌣	Physician Medical Examiner per partial-transit	ical Examiner	23a. Part1. Enter the shock, or heart Immediate Cause (f disease or condition resulting in death) Sequentially list conif any, leading to improve the cause. Enter Under Cause (Disease or in that initiated events resulting in death) Lease Control of the cause of th	Final Inditions, mediate tying njury	c	used the death. ch line. Or as a conseque or as a conseque or as a conseque or as a conseque or as a conseque	ence of):	he he	Co	and nt	iw l	TOS CUL	DI)	lar	Approximate Interval Between Onset and Death
P.O. Box 68	To the Hospital or Attending Physicien: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 r 1 □ Yes 2 ♥ 9 □ Unknown	months?		th 2 Fetal on the state of dealers	death 3	□Ectopic pi □ Other (sp		1				te of deliventh	ery Day Year
	es that tigned by	by Ph	Part II. Other signifi	cant condition	1s contributing to dea	ath but not resul	ting in the	underlying o	ause giv	en in Part	l.				the cause of death?
Records,	w requir been si should	eted										24a. Was	′es 2 No	3 Pro	babiy 4 Unknown opsy findings available
Rec	The lav	Completed										autop	rmed?	prior to co death?	ompletion of cause of 2□ No
ital	sien: artifice ctor, p	Bec	25. Was case referre	ed to medical							e of Dea	h Check only o			
of V	Physic this ca al dire	ို	1 ☐ Yes 2 🔀					nt 3 DC		4 LAN	ursing He	ome 5 Resid			fy)
ono	ding P th. After funera	tion:	27. Manner of Death 1 Natural 2 Accident	1 5 ☐ Pending investig		n, Day Year)	28b. Time Injury	M	28c. Injun Wor 1 🔲	yat k? Yes 2.⊑	No	28d. Describe n	low injury occur	180	
Division of Vital	To the Hospital or Attending Physicien: The lawithin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 Suicide 4 Homicide	6 Could n determin	ot be ned 28e. Place buildin	of Injury - At hor g, etc. (Specify)	me, farm, s	treet, factor	y, office			28f. Location (S City or Tow	Street and Numb m, State)	er or Rur	al Route Number,
_	Hospital 24 hours Funeral stely filled	edical C	29a. Certifier (Check only one)	1 Certifying 2 Medical E	Physician: To the examiner: On the ba and mann	sis of examinati	vledge, dea on and/or	th occurred nvestigation	at the tire, in my o	ne, date a pinion, de	nd place, ath occur	and due to the ored at the time, or	cause(s) and madate and place,	anner as and due	stated. to the cause(s)
	To the within To the comple	Me	29b. Sixtem and	title of certifier		7		29	c. Licens	e number	~2	~~	29d. Date signe	d (Month	Day, Year)
			Su	U4 (-	-4	aVI	~	1) 3	80	5	5	01/1	6/	06
	Sta Regist		30. Name and address 31. Date filed (Mont	BARR	vho completed cause A 26 32. Re	e of death (Item	1/1	Print)	1	Por	r 1	sou	4010	7 /	1) 21024
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			Fiease	State of Man					_	
		-	For State Registrar	State of Mar		rtificate of D			ZHUb	00744
			Registrar Decedent's Name (First, Middle, La.	st)		tillicate of D		Regi. 2. Date of Death	No.	3. Time of Death
	Physici	an	Leonard Will:		on			Month FANCES	Day Year	(010
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or I		4 Million	4c. County of Deal	
	<u> </u>		Berune wast	in to freque	al costa	- Greve	Surve		faure,	mass
	Funeral		5. Social Security Number 6. S		In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	B. Date of Birth (Month, Day, Yo	9. Birt	hplace (State or Foreign
	Director		220-30-1895	AM ZUF	72 Yrs.			Oct 17,		MD
	land		Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town or Lo	ocation				10d. Inside City Limits
	Mary	ğ	MD Anne	A 1 - 1		Glen Bu	rnio			1 ☐ Yes XXNo
	r 28a	irec	10e. Street and Number	Arundel		10f. Zip Code	ITHITE	10g	. Citizen of What Co	Jountry?
	be filed within 72 hours after death with the Maryland that Hygiene. Idea other than "natural", or items 23a or 28a-f show event, the Medical Ever'il ar mast be incitified at	by Funeral Director	315 New Jersey A	venue, NE		21	060		Ţ	JSA
	ems ems	ner	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent of His If Yes, specify Cuban	spanic Origin? (Spec	ify Yes or No-	14. Race - Ame Black, Whit	encan Indian,
36	s afte	Y.F.	1 Never Married 2 Married 3 Xwidowed 4 Divorced	1 A Yes 2 □ No If Yes, Give	1951	_	Specify:		Specify:	.,
21215-0036	tural Ex	pa pa	15. Decedent's E	Year or Dates:	1954	dent's Usual Occupat	tion	16	b. Kind of Business	nite Modustry
5.	n "na	Completed	(Specify only highest gra	de completed)	(Give	kind of work done du DO NOT use retired)	uring most of working	g	b. Itilia of basilless	modelly
212	d with giene. rr than	E	Elementary/Secondary (0-12)	College (1-4or 5+)		Diesel M	lechanic		Auton	notive
B	e filed al Hygia I other vent, t	Be C	17. Father's Name (First, Middle, Last,				18. Mother's Name	(First, Middle, Ma.		
Vai	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the Ms	10	Albert Thomas Kı	ichton			Margare	t Virgin	ia Brushw	ood
Maryland			19a. Informant's Name/Relationship (ng Address (Street ar	nd Number or Rural	Route Number, C	ity or Town, State, 2	Zip Code)
	perrit. Pages 1 and 2 Department of Health Importent: If item 27 any injury or other tri once.		Ms. Alberta Wiggi	ington / sis		New Jers				e, MD 21060
Baltimore,	0 O		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐			osition (Name of matory or other place			c. Location - City or	
Ë	perrit. Pag Department Importent: I any injury o		4 □ Donation 5 □ Other (Specif21. Signature of Funeral Service Licer		Gardens o		1/16/			Maryland Maryland
Ba	permit. Departr Importa any inj		21. Signature of Pulleral Service Licen		MO1357	2. Name and Address				Home, P.A.
	K		23a. Part1. Ever the disease, or com	plications that caused th	The second second		ond Ave S			Approximate
	Physician		shock, or heart failure. List only	one cause on each line.						Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (r as a	consequence of):	Frank Fr	nuix			Weeks
	Examiner		Conventially list conditions	Aut.	e home	Frances	·e			Leilla.
/-	p ±	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of):					
	ecute and trans	Examiner	that initiated events resulting in death) Last	C. Due to /or see a	consequence of):					
760,	ate be executed nysician and he burial-transit	cal E		Due to (or as a t	consequence on).					
687	phys phys s the		•	d						
Box (The law requires that the death certifica ate has been signed by the attending phoage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					23d. Date of de	livery
B	death e atte	Iclai	in the past 12 months?	1□Live birth 2 4□Pregnant at tir		□Ectopic pregnancy □ Other (specify)			Month	Day Year
0	t the by the	hys	9 Unknown	9□ Unknown						
S, P	as tha gned	by P	Part II. Other significant conditions	-		, ,		23e. Did tobac	cco use contribute to	the cause of death?
Records,	w require been signature	Completed by	Deserves	where); " an	muly	<u>~</u>	1 Tes	2 □ No 3 □ Pi	robably 4 Donknown
ecc	law ras be	ple	barthycon	na				24a. Was an autopsy	24b. Were as	utopsy findings available completion of cause of
- R		Con	•					performe		2 □ No
Vital	Physicien: The law this certificate has t ral director, page 2 s	Be	25. Was case referred to medical examiner?	l Hannitali		24	26. Place of Death			
of	Physi this c	2	1 Yes 2 No	Hospital: Inpatient			4 Nursing Hom			cify)
u o	ding After fune	tlon	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	/ear) Zeb. Talle C	Work	at ? ′es 2 ⊡No	8d. Describe how	injury occurred	
Division	Attending r death. ector: After by the fune	flca	3 Suicide 6 Could not b	O Co Place of Injury	/ - At home, farm, st			Bf. Location (Stree	et and Number or Ri	ural Route Number.
D	after after Dire	erti	4 Homicide	building, etc.	(Specify)	, , , , , , , , , , , , , , , , , , , ,		City or Town, S	State)	
	To the Hospitel or Attendwithin 24 hours after death To the Funerel Director:	edical Certification:	29a. Certifier (Check only 2 Medical Exa	nysicien: To the best of	my knowledge, dea	th occurred at the time	e, date and place, a	nd due to the caus	se(s) and manner as	s stated.
	the Hi in 24 the Fi	edic	one)	miner: On the basis of e and manner state	xamination and/or ir id.	ivestigation, in my op	inion, death occurre	d at the time, date	and place, and due	e to the cause(s)
	To To To To	Σ	29b. Signature and title of certifier	1110	MA	29c. License			Date signed (Mont	
	1		1 When	Mann	ero	1)-	46721	1	Huypu	7/30 rice
	5		30. Name and address of person who	completed cause of dea	th (Item 23a) (Type	Print) DARS	in and	CALLEY.	5 2	7 13 trac
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registar	s Signature	There Can	wire	us	4141	
	Regist		JAN 1	7 2006	mad Jr	freeles				

		1	For State Registrar	tate of Maryland / Depa Cer	artment of H tificate of			ene 2006	00745
			Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		William	Augustus	Keene	Sr.	January	16 2006	10:10 A ^M
	Examin		4a. Facility Name (If not institution, give stre	et and number)	4b. City, Town, o	or Location of Death		4c. County of Dea	th
			807 Umbre Street		Baltimo		O. D. to -4 Plat		Α
П	Funeral		5. Social Security Number 6. Sex 214-22-6810	7. Age (In yrs. last birthday) 2 F 79 Yrs.	Months Days		8. Date of Birth (Month, Day,)	Year) C	thplace (State or Foreign ountry)
	Director	-	Usual Residence of Decedent	19			July 19	1926 Ma	ryland
	yland		10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
	a-f s	ctor	Maryland NA	Baltimore					1 □ Yes 2 □ No X
	or 28	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What C	ountry?
	ath w		807 Umbre Street		21224			U.S.	Α.
	er de items	Funeral	11. Marital Status	Was Decedent Ever in U.S. 13. \ Armed Forces? 1946	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
36	ir, or	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Amed Forces? 1946 1 XYes 2 No If Yes, Give 1947 Year or Dates:	1 ☐ Yes 💥 No	Specify:		Specify: Wh	ite
21215-0036	within 72 hours after death with the Maryland ene. than "netural", or items 23a or 28a-f show fre M. dical Examiner must be notified at	ted	15. Decedent's Educati		dent's Usual Occu		11	6b. Kind of Business	
215	thin 7	Completed	(Specify only highest grade of Elementary/Secondary (0-12)	Colfege (1-4or 5+)	DO NOT use retire	during most of work d)	ng		
2	ified within Hygiene. other than	Con	6	NA Masonry	y Brick	and Block		Constructi	on
nd	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)	**		18. Mother's Name	First, Middle, M.		11.
Maryland	should be that all the marked or mar	L _o	John W.	Keene	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Mattie			llips
Nar	12 sho h and 7 is mu traum		19a. Informant's Name/Relationship (Type,					City or Town, State.	
	1 and Healt em 2 ther		William A. Keene J 20a. Method of Disposition	20b. Place of Dispo	sition (Name of		Date 2	ryland 21 Oc. Location - City or	
nor	ages int of t: if it	1	1 ☐ Burial 2 【XCremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	oval from State Bayview C1	natory`or other pla		ary _	saltimore,	
altimore,	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", or items 23a or 28a-f show any injury or other traumatic event, It a Modical Examiner must be notified at once.		21. Signature of Funeral Service Licenses						
Ba	permi Depa Impo any ir		1 Sulash all	Lomarke !	W. Dabrov	√ski/Chojn	acki Fun	eral Home	s P.A.
			23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one of						Approximate Interval Between
	Physician	l i	Immediate Cause (Final disease or condition						Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence of):		ER by Disi	-1.6		
8	Examiner		Sequentially list conditions, b.		AMEN	ناکا (۱ محر	142E		
1	sit ed	lue	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):					
V	sician and burial-transit	Examlne	that initiated events c resulting in death) Last	Due to (or as a consequence of):					
8760,	cate be executed physician and the burial-transit	dicai E							
9		edic	0						
Вох	death certific e attending p id for use as	M/II	230. was decedent pregnant	If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐	⊒Ectopic pregnanc	**/		23d. Date of de	
	ie deat the att	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No		Other (specify)	• 9		Month	Day Year
P.0	= > 0	Physiclan/Me	9 Unknown				as Pidus	4	4
	Se us	þ	Part II. Other significant conditions contril	ARU > -	inderlying cause gi	ven in Part I.	239. Did toba		o the cause of death?
ord	w requir been si should	eted	BENIGN	אמ כ	4 NEMTR	P 011			
Vital Records,	e law has t	Completed	NEMON	I KANIKIE KI	ALBICIK	· U 1 149	24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
al			05.186				1 ☐ Yes 2	No 1 ☐ Ye	s 2 No
ξ	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	pital: 1 ☐ Inpatient 2 ☐ ER/Outpatier	nt 3□ DOA O	hor	h (Check only one	nce 6 Other (Spe	north)
of	ding Phy h. After this funeral d			28a. Date of Injury 28b. Time o	f 28c. Inju	iry at	28d. Describe how		scriy)
ion	tending leath. tor: Afte the fun	atlo	X Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury		ork?]Yes 2 ☐No			
Division	er der recto	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office		28f. Location (Str. City or Town,	eet and Number or F State)	lural Route Number,
	itei o irs aft rei Di			•					
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edical	29a. Certifier (Check only one) Certifying Physic 2 Medical Exeminer	ien: To the best of my knowledge, deat : On the basis of examination and/or in and manner stated.	th occurred at the to estigation, in my	ime, date and place, opinion, death occur	and due to the cared at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier	Λ	29c. Licen	se number	29	d. Date signed (Mon	th, Day, Year)
)			I drait Myta	Je (Jon W)	0-	-48025		January 1	
	YA	1	30. Name and address of person who com	oferencause of death (ftem 23a) (Type,	Print) 224	(USA	co Av	E, DAJO	, UD21237
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signature	land.				
	riegist	THE S	JAN 1 7 200	D BERRESSE AND L					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

3:50 A

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 X Yes 2 ☐ No

Birthplace (State or Foreign Country)

Black, White, etc.

29d. Date signed (Month, Day, Year)

white

Specify:

Physician /Medical Examiner

PINSONNIAL DISABLY

burial-transit nding physicien ause es the burial ŏ

Records, P.O. Box 68760.

Division of Vital

death.

Examiner Be Completed by Physician/Medical Certification: To After this after death | Director: / d in by the f filled in within 24 hours a
To the Funerel C
completely filled i

Due to (or as a consequence of): INCONTINENCE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) 4☐Pregnant at time of death

IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Year 1 ☐ Yes 2 ₽ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? NOWE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 ₽No 2 No 1 Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 PNatural 5 Pending Injury 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 192 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

29c. License number

D0061519

10

Registrar

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

HEIGHTS RD, OWINGS MILLS, MD 21117

			1 - For Amend Item 23 Registrar	ot I,25 per II	arylan e, 9882	08/19/ Ce	tificat	nt of H	ealth and Death	Mer	tal Hyg	giene Reg. No	006	007	47
4.	1 7 7 7	jaj-	Decedent's Name (First, Middle, L.							2.	Date of Dea	ath Day		3. Time o	
* 0	Physici /Medic		NEAN HAR	DLD K	AND	W				J	unuar	4	11 2001		15 4
	Examin		4a. Facility Name (If not institution, g	ve street and number)			_		Location of De			4c.	County of Death	5	
- 4	Y 1	425 .	Memorial Ho	sprtal	no (la ura i	in at histholous		AS +	If Under 24 H	rs. R	Date of Birt	h	lalbo		or Foreign
	Funeral Director		5. Social Security Number 6. 213 – 82 – 0609	Sex 7. As 1- M 2□ F	79. iii yis. i	ast birthday) Yrs.	Months		Hours Mi	n. 00	CT.27	у. Үөаг) 7 Т	926	oplace (State untry)	iE
	10		Usual Residence of Decedent	Λ			1				J	,			
	how		10a. State 10b. County			y, Town or Lo								10d. Inside C	City Limits 2 T√No
	the Marylar 28a-f show	cto	MD QUEE	N ANNE		GRASO:						40.00			X.
	vith th	Die	10e. Street and Number	IIN DOAD			101. Zij	p Code	2163	Q		Tog. Cit	izen of What Co	USA	
	72 hours after death with the Maryland natural', or iteme 23a or 28a-f show disal Examiner must be multified at	by Funeral Director	112 GRAVEL R	12. Was Decedent	Ever in U.	S. 13.	Was Dece	dent of Hi	spanic Origin? n, Mexican, Pu		Yes or No		14. Race - Ame		
10	fter d	F	1 ☑ Never Married 2 ☐ Married	Armed Forces	?					erto Rica	an, etc.)		Black, White		171
5-0036	ral', o		3 ☐ Widowed 4 ☐ Divorced	If Yes, Give ** Year or Dates:			1 🗆 Yes	2X No	Specify:				Specify:	WHIT	. Ł
5-0	72 hc	Completed	15. Decedent's (Specify only highest of			16a. Dece (Give	kind of wo	ork done d	furing most of v	vorking		16b. K	ind of Business/	Industry	
121	within ene. then "	mp	Elementary/Secondary (0-12) NONE	College (1-4or	5+)		do noti TRAC		•			CHI	ESTERWY	E CEN	ITER
d 21	Hygie Hygie other t	ပိ	17. Father's Name (First, Middle, Lat	st)		0011			18. Mother's N	iame (F	rst, Middle,	Maiden	Sumame)		
an	d be ental ked o	To Be	MORRIS		I	KANOW			ESTH:	ER				YOSS	SIN
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla if Health and Mental Hygiene. Item 27 is marked other than "natural", or iteme 23a or 28a-1 show other traumatic event, ite Medical Examiner must be multipled at	-	19a. Informant's Name/Relationship	(Type, PrintASSIS	STANT	19b. Maili	*						or Town, State, 2		
	and 2 alth a 27 is		JANET AKERS /	ADMIN.		110			RWYE L				ONVILLE		2163
ore			20a. Method of Disposition 1 X Burial 2 Cremation 3	Removal from State		lace of Dispo emetery, cre	osition (Na matory or	me of other plac		Date			ocation - City or		
Ĕ	r it e		4 Don tkn 5 Dother (Spe	my //	EBI		OUNG				2006		WOODLAV)
Baltimore	permit. Page Department of Important: If eny injury or once.		21. Signature Funeral Pervice Lin	ensee//									& BROS.		200
	40104	-	23a Part 1 Enter the disease or co	molications that cause	d the deat								SVILLE,	Approxima	ate
			23a. Part 1. Enter the disease, or co shock, or heart failure. List on tmmediate Cause (Final									14	EXAMINER	Intervat Be Onset and	
	Physician /Medical		disease or condition resulting in death)	a. PNE Due to (or a		DN/A					1 1	EDICAL	EXAMIL	ZNE	eks
ę	Examiner			,	ZUR					LA	ROVEDBY	Min			
*	<u> </u>	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a					O CERTIFIC	AT .					
8	executed in and ial-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. CHPON	W I	BSTK	45.71	V.	PULMO	166	y /	15	455		
50,	be executed sicien and burial-transit		resulting in dealin, cast	Due to (or a	s a conseq	luence or):	Down	Synd	lrome		en de	, .	-1/V	70	
8760	ate hys	dical		d.	INC	KI	FIRE	DHI	070 701	77 E	OTO NO.	2 21	NBAUNT	-7-7	
9 x	eath certific attending p for use as	/Me	IF FEMALE:	23c. If yes, outcom									23d. Date of del	ivery	
Вох	seath atter	clar	23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{Yes} 2 \subseteq \text{No} \)	1□Live birth 4□Pregnant			⊒Ectopic (□ Other (s						Month	Day	Year
0	t the d by the ached	hysi	9 Unknown	9∐ Unknown											
G.	The law requires that the death certific is the bas been signed by the attending page 2 should be detached for use as	Completed by Physician/Med	Part II. Other significant condition			sulting in the	underlying	cause giv	en in Part I.				use contribute to		
rd	w require been sig should b	ed	HTIPEI	e TENSION	J					-	1 🗆	Yes 2	!∐No 3∐Pi	obably 4 🖺	Linknown
မင္ပ	e law re has be je 2 sh	ple								_	24a. Was	psy	prior to	utopsy finding completion of	s available cause of
H		Con									1 Yes	ormed?	death? 1 ☐ Yes	2 □ No	
Division of Vital Records,	Attending Physician: Th r death. ector: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Oth	26. Place of I				. 570		
of	Phys this ral dir	2	1 A Yes 2 No 27. Manner of Death	1 x Inpa		ER/Outpatie 28b. Time		28c. Injur Wor	4 LINUISIN				6 ☐Other (Spe ury occurred	city)	
on	ding Ph th. After th funeral	tho	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of In (Month, E	lay Year)	Intury	М		k? Yes 2∐No						
/isi	Attend r death octor: A	fica	3 Suicide 6 Could no determin		njury - At h	ome, farm, s	treet, facto	ory, office		28f	Location (nd Number or R	ural Route Nu	mber,
á	교 왕 교	Certification: To	4 Homicide	Building,	віс. (Зресл	(y)					Ony or 10	wiii, Otat			
	To the Hospital or within 24 hours efte To the Funeral Dir completely filled in	edical	29a. Certifier 1X Certifying (Check only 2 Medical E	Physician: To the bestaminer: On the basis	of examina	owledge, dea	th occurre	d at the tir	me, date and pl	ace, and	due to the	cause(s	s) and manner as	s stated. to the cause	(s)
	the H nin 24 the F nplete	Medi		and manner				9c. Licens					ate signed (Moni		
	or vit	-	29b. Signature and title of certifier	•	de N										
	_		20 Normand	MMA no completed cause of	(death (the	m 23a\ /Tuc-	Print'	ンで	1001			U	112/06		m A .
	. 7	-	30. Name and address of person w	ORA	Yn n	11 / N	RMOR	CIAL	HOSPITA	92,	219	5.0	IZ 06 NEHING EASTON	J MIDS	(RFET,
45	S	tate	31. Date filed (Month, Day, Year)	207	strar's Sign	ature	A+-	~					0,000		12/1/
. 4	Regis		JAN 1 5	2006		12 1	Track	1							

Kanow, Dean

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. U Decedent's Name (First, Middle, Last) 2. Oate of Death Physician Month JAN 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Parkville Genesis Loch Raven Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | Feb. 18, 1947 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2/2 MF Maryland 218-46-0799 58 Yrs Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ont: If item 27 is marked other then "naturel", or Items 23a or 28e-1 show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or Items 23a or 28e-1 shov the Modical Examiner must be notified at Maryland Baltimore Essex 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1257 Damsel Road 21221 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 200No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo þ Specify: 3 Widowed 4 Vorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2 Quality Control Manager Plastic Manufacturer or other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frederick M. Sporrer Margaret Walsh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 813 N. Marlyn Avenue, Baltimore, Maryland 21221 Brian Sporrer (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ₩ Burial 2 Cremation 3 Removal from State permit. Page Department of Importent: If eny injury or Jan. 16, 2006 Baltimore, Maryland Gardens Of Faith 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Pure and Service Licensee 22. Name and Address of Facility Ski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final diseas) or condition resulting in death) Physician nave /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Be Completed by Physician/Medical Examiner Due to (or as a consequence of) burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) P.O. I been signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? 2 No 1 Yes 2) No Hospitel or Attending Physicien: director 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 😿 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation hours after deat unerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 | Homicide Fo the Funerel Dir 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner and due to the cause(s) and manner stated.

**Death Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and little of certifier 29d. Date signed (Month. Day, Year)

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature

JAN 1 7 2006

30. Name and address of person who completed cause of

ORIGINAL

eath (Item 23a) (Type, Print)

_			State of Maryland / Department of Maryland / D	artment of Health and M tificate of Death		ene 0 0 6	00749
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Jeane M. Kelley		2. Date of Death Month	Day Year 12-06	3. Time of Death
	Examin Funeral Director	er	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 219-18-9423 1 M 2007 81 Yrs.	4b. City, Town, or Location of Death Rosedale If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth 10–18–1	Ac. County of Death Ba (fi mo) 9. Birth Cou Mar	re place (State or Foreign ry) and
	the Maryland 28e-f show	Jo.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo MD Baltimore Baltimore				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	ath with the Maryla 23a or 28e-f ehor	Funeral Director	10e. Street and Number 305 Patapsco Ave.	10f. Zip Code 21237		g. Citizen of What Cou	
9036	after dez or iteme	d by Funera	11. Marital Status 1 ☐ Never Married 2 ☐ Marnied 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No. 13. 1	Mas Decedent of Hispanic Origin? (Spef Yes, specify Cuban, Mexican, Puerto □ Yes 2(X)No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Wh	
Jeane 21215-0036	TO CO 2	Be Completed by	(Specify only highest grade completed) Elementary/Secondary (0-12) 9th (Give life. Life of the life. Life of the life. Life of the life. Life of the life. Life of the life. Life of the life. Life of the life. Life of the life of th	dent's Usual Occupation kind of work done during most of worki DO NOT use retired) Sewife	ing	6b. Kind of Business/In	dustry
Iryland	s 1 and 2 should be file. If Health and Mental Hyg. Item 27 is marked othe other traumatic event,	To Be	17. Father's Name (First, Middle, Last) Walter Kozlakowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailin	Josephine g Address (Street and Number or Rura	e Chmel		o Code)
e eu	ages 1 and 2 : nt of Health ar ; if item 27 is or other trau		Charles Kelley/Husband 305 P. 20a. Method of Disposition Cameleny, Crem. 10 Burial 2 Cremation 3 Removal from State Cameleny, Crem.	atapsco Ave. Balt sition (Name of natory or other place)	Date 20	21237 0c. Location - City or To	own, State
Baltin	permit. Pages Department of important: if is any injury or once.		21. Sign Turel of F neral Service Licensee M22	Name and Address of Facility Name and Address of Facility 15 Belair Rd., Bal	al Home	Baltimore,	MD .
8760,	Physician /Medical Examiner	sai Examiner	23a. Part. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, Jeaning to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	er the mode of dying, such as cardiac conflure no Di	or respiratory arres	st.	Approximate Interval Between Onset and Death
P.O. Box 68	Hospitel or Attending Physicien: The law requires that the death certificate be executed to hours after death. Funerel Director: After this certificate has been signed by the attending physicien and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 monWs? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ery Day Year
cords, P.	aw requires that the de ts been signed by the a 2 should be detached t	Completed by Ph	Part II. Other significant conditions contributing to death but not resulting in the ur Atrial fibrillation Advancedy Dementia	Inderlying cause given in Part I.	1 🗓 Yes 24a. Was an	24b. Were auto	psy findings available
ital Re	icien: The la certificate ha rector, page 2	a	25. Was case referred to medical	26. Place of Death		ed? death? DNo 1 ☐ Yes	impletion of cause of
Division of Vital Records,	utending Physicis death. ctor: After this cer y the funeral direct	ertification; To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Accident	t 3 DOA Other: 4 Nursing Hor		ce 6 Other (Specif	y)
Divis	Itef or Attencirs after death rei Director: led in by the	O	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, strubulding, etc. (Specify)		City or Town,		
	To the Hospitef or A within 24 hours after To the Funerei Dire completely filled in b	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death (Check only one) 1 Medical Examiner: On the basis of examination and/or invariant and manner stated.	vestigation, in my opinion, death occurre	ed at the time, date	e and place, and due to	the cause(s)
	Twit		29b. Signature and title of certifier An American and address of person who completed cause of death (from 33a) Times	29c. License number 00059385		1. Date signed (Month, 0//12/06	,
1	Sta	to	30. Name and address of person who completed cause of death (Item 23a) (Type, OSE ph N - FUSC of 100 MO 9705 From 31. Date filed (Month, Day, Year) 32. Registrar's Signature	roklih Sovere Drive Su	ite 312 Ba	Himere MO	2/237
	Registi		31. Date filed (Month, Day, Year) JAN 1 7 2006 32. 98 gistrar's Signature	and I			

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State of Maryland / Department of Health and Mental Hygiene

			Tor State Registrar	State of Marylan		artment of			giene	006	0075	N
			Decedent's Name (First, Middle, Last)					2. Date of Dea	ath		3. Time of De	ath
	Physicia /Medic		Margaret Lenore La	mbert.				Month	Day	Year	1:50 6	> M
	Examin		4a. Facility Name (If not institution, give s			4b. City, Town	, or Location of Deat		4c.	County of Death)	
	4,17.		St Agnes	HOSDIMI		Bali	rimore			1	ī/A	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Day		(Month, Da	y, Year)	Cot	place (State or Fountry)	
	Director		577-18-6544 Usual Residence of Decedent	M 2124 86				June 1	9,19	19 Wash	nington,	<u>D.C.</u>
	/land		10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City L	imits
	Man a-f sh	tor	Maryland Baltimore	e County Ca	tonsvi	lle					1 ☐ Yes 2	⊠ No
	h the	Director	10e. Street and Number			10f. Zip Code)		10g. Citi	izen of What Cou	untry?	
	23a (ai	123 Fairfield Ave.				21228		Un	ited Sta	ates	
	r dea	Funerai	The state of the s	Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of f Yes, specify Ci	f Hispanic Origin? (S uban, Mexican, Puer	pecify Yes or No to Rican, etc.)	-	14. Race - Amer Black, White		
36	be tiled within 72 hours after death with the Maryland lat Hygiene. d other than "natural", or liems 23a or 28a-f show event, the Medical Exertil et final the notified at	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐Yes 2 🔯 No If Yes, Give		1 □ Yes 2 ½ N	lo Specify:			Specify: TJ	nite	
21215-0036	hour fural	edt	15. Decedent's Educ	Year or Dates:	16a Dece	dent's Usual Occ	unation		16h Ki	ind of Business/l		
15	n' na n "na	Completed	(Specify only highest grade	completed)	(Give		ne during most of wo	rking	100.10	or Dag	ildustry	
212	d with giene. or than	E	12	College (1-4or 5+)	Se	cretary			Fed	eral Gov	vernment	
	be filed tat Hygi d other event, t	Bec	17. Father's Name (First, Middle, Last)			J .	18. Mother's Nar	me (First, Middle,				
<u> a</u>	should b and Ments marked umatic e	2	John I. King				Rose Moi	ney				
Maryland	and s m		19a. Informant's Name/Relationship (Typ		1		et and Number or Ri				, ,	
	as 1 and 2 of Health item 27 i		Mr. Raymond W. Lam			Brushfi sition (Name of	eld Court	Apt.A				
0	ges it of F.		20a. Method of Disposition	1 0	emetery, crei	natory or other p	Jan	.16.2006		ocation - City or 1		
Baltimore,	t. Pa rtmer rtant: njury		' 4 □ Donation 5 □ Other (Specify)			alley M	em.Gar.		Timo	niun,Mar	ryland	
Ba	permit. Pages Department of P Important: if ite any injury or of		21. Signature of Funeral Service License	F. gan, k	2 . B	eaceful 25 York	Alternativ Road Tir	ves Fune	ral& Mary	Cremation 2	n Ctr.,	P.A.
			23a. Part . Enter the disease, or complications, or heart failure. List only on	cations that caused the death e cause on each line.							Approximate Interval Between	3n
	Physician		Immediate Cause (Final disease or condition	400		CANCE					Onset and Dea	
	/Medical Examiner		resulting in death)	Due to (or as a conseq								
k		Ļ	Sequentially list conditions, b	. Due to (or as a conseq	(ana af)							
W	ted	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Dissess or injury)	Due to (or as a conseq	uerice or).							
8	al-tra	xar	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):							
8760,	cate be executed physician and the burial-transit	dical										
9		ledi										
Вох	that the death certifi ed by the attending detached for use as	Physician/Me	23b. was decedent pregnant	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		⊒Ectopic pregna	ncv			23d. Date of deliv		
	e dea he att	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of d		Other (specify)				Month	Day Yea	1
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oro	w requir been si should	eted			-							
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Vital		o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 Inpatient 2				ath (Check only o				
of		-	27. Manner of Death	28a. Date of Injury	ER/Outpaties 28b. Time of		Other: 4 Nursing Figury at Vork?	28d. Describe I			ity)	-
on	를 돌 호	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		Vork? □Yes 2□No					
Division	or Attendate death Director:	ertification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he	ome, farm, st	reet, factory, offic	20				ral Route Number	
ō	tal or A	Cert		building, etc. (Specif	7/			City or To	, Glate	"		
	To the Hospital or within 24 hours after To the Funeral Director completely filled in D	edical	29a. Certifier 12 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my knower: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred at the vestigation, in m	time, date and place y opinion, death occ	e, and due to the urred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)	
	Fo the	Me	29b. Signature and title of certifier	2		29c. Lice	ense number		29d. Da	te signed (Month	, Day, Year)	
	- > - 0		I CKE K	Mu	10	Do	00 25 84	4	57/1	UJARY	14 200	3 5
	10		30. Name and address of person who co	mpleted cause of death (Item	n 23a) (Type,	Print) 54	1 040	mesoci	c.ex	RO	#18	
	b		CHRISTING L. C	comertee 20	mis	BA	1 00	EIM	1.9/	reno	2122	9
	Sta Regist		31. Date filed (Month, Day, Year)	32. Renis car's Signa	ture	AST.						

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend items 7.8 20h Coper Th 8855 5 24-06 What Hygiene State of Maryland Poepartment of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 13, 12:20 A M January Etta Mae Lewis 2006 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Charles 10008 Tallahassee Place Waldorf 1923 ar) 9. Birthplace (State or Foreign Country) Louisiana 5. Social Security Number 7. Age (In yrs. last birthday) Months 82 -1 ☐ M 2 ☐ F Yrs 438-36-5456 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Orleans Gretna 10f Zin Code 10g. Citizen of What Country? 10e Street and Number 70056 780 Behrman Highway U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify Specify: Black 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria Supervisor School Board 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Smith Lizzie Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10008 Tallahassee Pl., Waldorf, MD Hazel Lewis (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Avondale, Louisiana 20a. Mathod of Disposition 21^{Date}06 1 Burial 2 □ Cremation 3 □ Removal from State 1 - 19 - 05Avendel, PA 4 ☐ Donation 5 ☐ Other (Specify) Restlawn Cemetery 22. Name and Address of Facility
Rhodes Funeral Home
2929 Scenic Highway, Baton Rouge, LA 70805 21. Signature of Funeral Service Licenses Mucu ennus Approximate Interval Between Onset and Peath 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) VBSCU LAN ERRBRAN Due to (or as a consequence of) AR RIKY, Y Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 2501 Dag 12 Due to (or as a consequence of)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a, State

LA

Director

Funeral

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Completed

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or itema 23a or 28a-1 show any injury or other traumatic event, tra Medical Exercical months actified at ADE.

Baltimore, Maryland 21215-0036

Examine transit and physician ar s the burial-t Physician/Medical as attending USB jo the detached signed by þ 99 page 2 should Completed peeu has certificate the Hospital or Attending Physician: hin 24 hours after death the Funeral Director: After this certifica director, Be ၉ by the funeral Certification:

The law requires that the death certificate be executed

P.O. Box 68760

Division of Vital Records.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 9 Unknown

23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 4 Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

1 ☐ Yes 2 ☐ No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed? 1 Tes 2 No

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

Daughter's

3 Probably 4 ⊠Unknown

Day

Year

25. Was case referred to medical examiner? 1 ☐ Yes 2 🗓 No

27. Manner of Death 1 XNatural 5 Pendina investigation 2 Accident 3 Suicide

28a. Date of Injury (Month, Day Year) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient

Other: 4 Nursing Home 5 Residence 6 Other (Specific Residence 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28b. Time of Injury М

1 ☐ Yes 2 ☐ No

Location (Street and Number or Rural Route Number, City or Town, State)

23e. Did tobacco use contribute to the cause of death?

(Check only one) 29b. Signature

4 Homicide

238 Cartifier

1 L. Cartifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date sighed (Month, Day Year) 29c. License number

26. Place of Death Check only one

ho	2 Howk	Lim	
and address of p	per on who completed cause of	death (Item 23a) (Tyw.	Prin

32. Registrar's

DHMH 17 Rev 1/2001

within 24 hours after To the Funeral Dire completely filled in b

Medical

State Registrar

		•	1 - Stata Registrar	,	d / Department of H Certificate of			ZUU5	00132
			Decedent's Name (First, Middle, Last)				2. Date of Death	n	3. Time of Death
	Physicia		DONNA	L. L	-YNN		Month	Day Year	2.23 AM
}	/Medic Examin		4a. Facility Name (If not institution, give stree			r Location of Death	•	4c. County of Deat	- 1
	LAGIIIII	CI	NORTH ARUNI	EL HOS	FITAL GREN	BURNIT	E. MD	ANNE	ARUNDEL
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. Ia	ast birthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		thplace (State or Foreign
	Director		231-36-1323 ^{1□ M}	2 X □ F 73	Yrs. Months Days	Hours Min.	Oct 24,	1932 V	irginia
			Usual Residence of Decedent						
	ylan		10a. State 10b. County	10c. City	, Town or Location				10d. Inside City Limits
	Mar-f	ģ	Maryland Anne Arun	de1	Severn				1 Tyes 2 No
	r 28	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Co	ountry?
	h wit		7871 Bastille Place			21144		United St	tates
	deat	Funeral	11. Marital Status 12.	Was Decedent Ever in U.S	S. 13. Was Decedent of H	lispanic Origin? (Spe	ecify Yes or No-	14. Race - Ame	erican Indian,
ထ	or Ite	교	1 Never Married 2 Married	Armed Forces? 1 Yes 2 XNo		an, Mexican, Puerto	Hican, etc.)	Black, Whit	e, etc.
8	ours all, c	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 📉 No	Specify:		Specify: Wh:	ite
21215-0036	within 72 hours after death with the Maryland ene. Than "natural", or Items 23a or 28a-f show Ite Medical Examinat must be notilled at	Completed	15. Decedent's Education (Specify only highest grade co		16a. Decedent's Usual Occup (Give kind of work done	pation	1	16b. Kind of Business	/Industry
7	hin 7	pie		College (1-4or 5+)	life. DO NOT use retire	d)	,,,9		
7	filed withi Hygiene. other then	NO.	12th		Homemaker			Own Hor	me
b	e file al Hy oth	Be (17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, M	faiden Sumame)	
<u>a</u>	ould be Mental Marked o	2	Hannon Mosley	Browder		Mary	Jennir	ngs Chr	istianson
Maryland	ts Di in		19a. Informant's Name/Relationship (Type,	Print)	19b. Mailing Address (Street	and Number or Rura	al Route Number,	City or Town, State, 2	Zip Code)
	1 and 2 Health a tem 27 Is		Donald F. Lynn/ Hus	band	7871 Bastille	Place	Severn,	Maryland :	21144
Baltimore,	s 1 a f He item othe		20a. Method of Disposition		ace of Disposition (Name of ametery, crematory or other pla.	ce)	Date 2	20c. Location - City or	Town, State
9	Pages nent of I ant: If Ite		1 ☐ Burial 2 【XCremation 3 ☐ Removed 1 ☐ Burial 2 【XCremation 3 ☐ Removed 1 ☐ Donation 5 ☐ Other (Specify)	ioval from State	: Arundel Crema		/2006 0	denton M	aruland
≣	그는만큼		21. Sign to re of Funeral Service Acensee	WESC	22. Name and Addre	ss of Facility			
Ba	Dermi Depa Impo eny ir		M & DUD	majo	Donaldson	Funeral H	lome & Cr	rematory,	P.A.
	-		23a. Parti Enter the disease, or complications shock or heart failure. List only one complications are constituted in the control of the cont		Do not enter the mode of dvir	OOLIS KOAD	or respiratory arre	on, Maryla	
			shock or heart failure. List only one of immediate Cause (Final	cause on each line.	// /	1.00	1000		Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	11/40 C	andial	1 11	and	RON	16- 0
	Awedicai						1		nour
	Examiner			Due to (or as a consequ	ience of):	20 167	7		Thour
	Examiner	L	Sequentially list conditions b. –	Diale	ces	Inf Mellit	t us		710 yrs
		iner	Sequentially list conditions b. –	Due to (or as a consequence to (or as a consequence)	ces	nellit	tus		Noyro
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8760,		licai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence	erros or).	mellit	tus		Noyrs
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			1 _ State	epartment of Health an Certificate of Death		7 H H b	00753
		2	Registrar 1. Decedent's Name (First, Middle, Last)	Definicate of Death	Reg.	No.	3. Time of Death
	Physici		BENJAMIN	LEVIN	JANUARY	Day Year 12, 2006	10:55 P M
5	/Medio		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of D		4c. County of Death	1
		4	MILFORD MANOR NURSING HOME	BALTIMORE		BALTIMORE	
100	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Months Davs Hours	Hrs. 8. Date of Birth (Month, Day, Ye 2/22/191	9. Birthp	lace (State or Foreign try)
-4F.	- Director		220-03-1490 1 1 M 2 H 93 Y Usual Residence of Decedent	rs.	2/22/191	.2	MD
	yland 10W		10a. State 10b. County 10c. City, Town	or Location		1	Od. Inside City Limits
	a-fsh	tor	MD BALTIMORE B.	ALTIMORE			1 ☐ Yes 2 ☐ No
	ith the	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Coun	itry?
	ath w		4202 OLD MILFORD MILL ROAD	21208		USA	
	itams	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 🕅 Married 1 □ Yes 2 🕅 No	 Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F 	? (Specify Yes or No- ruerto Rican, etc.)	14. Race - Americ Black, White,	
920	urs af	þ	3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 🂢 No Specify:		Specify:	WHITE
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show the Modical Examiner must be notified at	Completed	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work done during most of	l working	b. Kind of Business/Ind	dustry
2	Athin ne.	mpie	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)		EVED (OF	
	l be filed water Hygie od other to event, It.		1 D	ISTRICT MANAGER	Name (First, Middle, Mai	SEVERAGE	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan by Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other treumatic event, it a Modical Exteniner must be notified at	To Be		EVIN RACH		30.7 3 3 .114.115)	COHEN
ary	2 should and Men is marke	-		Mailing Address (Street and Number of	· · · · · · · · · · · · · · · · · · ·	ity or Town, State, Zip	
	1 and 2 Health a lem 27 is		GAIL SHUGARMAN / DAUGHTER 2	914 OLD COURT ROA	D - BALTIMOR	E, MD 212	808
altimore,	of He		1 N Burial 2 Cremation 3 Removal from State cemetery	Disposition (Name of , crematory or other place)	Date 200	c. Location - City or To	wn, State
Ĕ	Pag ment tant: I		4 Donation 5 Other (Specify)		1/15/2006	WOODLAWN,	MD
Bal	permit. Pages Department of th Important: If its any injury or of		21. Signature Funeral Service Licensee	22. Name and Address of Facility 8900 REISTERSTON	SOL LEVINSON	-	
ġ.			23a. Párt1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.				Approximate
	Physician		Immediate Cause (Final disease or condition	unionyoputh		1	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence o	1):	4		
- 10		_	Socientially list conditions, france, leading to immediate Due to (or as a consequence of	1)*			
	ted insit	Examiner	cause. Enter Underlying Cause (Disease or injury	<i>J</i> -			
o î	cate be executed physicien and the burial-transit		that initiated events c. resulting in death) Last C. Due to (or as a consequence or	·):			
8760,	ate be nysicie ne bui	dicai	d				
9	ing ph	Med	IF FEMALE:			1	
Вох	The law requires that the death certifi ste hes been signed by the attending I bage 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 Ectopic pregnancy		23d. Date of delive Month	ory Day Year
P.O.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)			
	that hed by deta	by Ph	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobac	co use contribute to th	ne cause of death?
Vital Records,	w requires that been signed t should be det		Drohy ythronia		1 ☐ Yes	2 □No 3 □ Prob	ably 4 Dunknown
000	awre s bee 2 sho	Completed	, ,		24a. Was an		psy findings available
Ĕ	The law ete hes l page 2 s	mo			— autopsy performed 1 Yes 2	death?	πpletion of cause of 2 ☐ No
ita	ysician: The lis certificete he director, page	Be	25. Was case referred to medical examiner?	26. Place of	Death (Check only one)		
of \	Physician: r this certific ral director,	P	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Out		ng Home 5 Residence)
u C	After fune	ion:	12-1 value of 1	me of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	
Division	Attending r death.	fica	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, far			et and Number or Rura	I Route Number.
S	el or /	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, S	State)	
	To the Hospital or Attending Phwithin 24 hours effer death. To the Funeral Director: Affer the completely filled in by the funeral		29a. Certifier (Check only (Ch	death occurred at the time, date and p	place, and due to the caus	e(s) and manner as st	ated.
	To the H within 24 To the F complete	Medical	and manner stated.				
	Viti To Con	-	29b. Signature and title of confiner	29c. License number	29d.	Date signed (Month, I	uay, rear)
•	1		71	Type Brief		11.9/20	
	3		30. Name and address of person who completed cause of death (Item 23a) (1838 Green	re Tree 1	Ed 2	1208
Th.		ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature		-	- 3	
*	Regist	rar	JAN 1 7 2006 Magaza Al	Souls!			

DHMH 17 Rev 1/2001

ORIGINAL

Please	Type or Print in Black	Indelible Ink. Ensure A	II Copies Ar	e Legible.	
_		partment of Health and I		-	
1 - For State Registrar		ertificate of Death	Reg.	2000	00754
1. Decedent's Name (First, Middle, La	ast)		2. Date of Death Month	Day Year	3. Time of Death
Ormsby Smith	Moore		January 1		1:15 A M
4a. Fecility Name (If not institution, gir	ve street and number)	4b. City, Town, or Location of Death	1	4c. County of Deat	
Gilchrist Cente		Towson		Baltimor	
212-26-2680	Sex 7. Age (In yrs. last birthd	Months Days Hours Min	8. Date of Birth (Month, Day, Ye Dec. 10,	1927 Ma	nplace (State or Foreign untry) LYLand
Usual Residence of Decedent 10a, State 10b, County	10c. City, Town o	r Location			10d. Inside City Limits
Maryland Baltim		ettingham			1 ☐ Yes 2 No
10e. Street and Number		10f. Zip Code	10g.	Citizen of What Co	untry?
4335 Penn Aven	ue	21236		U.S.A.	
11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Ame Black, White	
1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	1 MYes 2 □ No If Yes, Give WW II Year or Dates:	1 ☐ Yes 2 🏋 No Specify:	o riican, etc.,	Specify:	white
15. Decedent's E (Specify only highest gi	rade completed) (G	ecedent's Usual Occupation Give kind of work done during most of wor	rking	b. Kind of Business/	
Elementary/Secondary (0-12)	College (1-4or 5+)	fe. DO NOT use retired) LV ELOPET		elf-Emplo <u>i</u> Eveloper	jeu
17. Father's Name (First, Middle, Las	it)		ne (First, Middle, Mai	iden Surname)	
Edmund Moore		Elizab	eth Smi	th	
19a. Informant's Name/Relationship		lailing Address (Street and Number or Ru		-	Zip Code)
Mrs. Rayola Hurt		55 Penn Avenue, Not			
20a. Method of Disposition 1	Removal from State cemetery,	isposition (Name of crematory or other place) apel UMC Cem. 1/19		c. Location - City or Crru Hall.	
21. Signature of Funeral Service Lice		22. Name and Address of Facility Sc. 9705 Belair Rd., B	himunek Fu	ineral Hon	
	mplications that caused the death. Do not y one cause on each line.				Approximate Interval Between
Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequence of)	tic CANCER			Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to (or as a consequence of)				
Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of)				
•	d				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of del Month	ivery Day Year
Part II. Other significant conditions	s contributing to death but not resulting in the	he underlying cause given in Part I.	23e. Did tobai 1 ☐ Yes	4	o the cause of death?

Examiner

Physician

/Medical

Examiner

Director

Completed by Funeral

To Be (

Funeral Director

the Maryland

Examiner Be Completed by Physiclan/Medical Certification: To

Medical

Sequenti if any, les cause. E Cause (E that initia resulting IF FEMA 23b. Wa in th Part II. O 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No rmed? 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of t Matural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place; and due to the nausa(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (flem 23a) (Type, Print)

Casti Bultz and Zizox

31. Date filed (Month, Day, Year)



Registrar

		-	For State Registrar	State of	Marylan		artmen rtificat			and M		Reg. No	UUD)	007	55
	Physici	۰ ۲۵	Decedent's Name (First, Middle, La.	st)							Date of De Month	ath Da	y Y	ear ,	3. Time of	Death
-	/Medic	al	DAVID LEN		MOR						JAN	12			1:51	PM
	Examin	er	4a. Facility Name (If not institution give Bultimore WA Relet	street and numi	(Gas C	enten	4b. City,	Town, or	Location of	of Death		40	. County of	Death		
							10	all	Orre	UE 34 400 T					10:	
	Funeral		5. Social Security Number 6. S	ex OXM 2□F	. Age (In yrs.	last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da			Cour	,,	r Foreign
₩	Director	-	112-40-6518 Usual Residence of Decedent		56		<u> </u>				02/16/	1949	N	ew	York	
	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							1	0d. Inside Ci	ty Limits
	Mary 1 sh	to	Maryland			Baltim	ore								1 XYes	2 🗌 No
	r 28a	rec	10e. Street and Number			Dartin	10f. Zip	Code				10g. Ci	tizen of Wh	at Coul	ntry?	
	death with the Maryland ma 23a or 28a-f ahow rmust be notified at	Funeral Director	1 West Conway	Street	Apt.	613	:	2120	1			11.	S.A.			
	ma 2	ner	11. Marital Status	12. Was Deced						gin? (Spe	cify Yes or No Rican, etc.)		14. Race -			
9	ours after death with the Marylan elf, or itema 23e or 28e-1 ehow Examiner must be notified at	Fu	1 Never Married 2 ☐ Married	1 □XYes 2	.□No 19	74	1 Yes		Specify:		ilcari, etc.)			White,		
21215-0036	hours after ture!', or its at Exemine	d by	3 Widowed 4 Divorced	Year or Da	es: 19	79			- Op00::/				Specify:	ьта	CK	
ς, O	n 72 hours "natural", adical Ex	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)		(Give	dent's Usua kind of wo	rk done d	durina mos	t of workir	ng	16b. k	(ind of Busi	ness/In	dustry	
2	within ene. then	d E	Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	DO NOT U)							
	filed v Hygie ther t	ပိ	12 17. Father's Name (First, Middle, Last)			We1d	ler	18 Mothe	ar's Name	(First, Middle		nstru	cti	on	
anc	ntal h	Be									Cope	, 1110100	, obmanio,			
Ž	should be nd Mental nmarked	^L	Harold Morris 19a, Informant's Name/Relationship (Type Print)		19h Maili	na Address	(Street		-	l Route Numb	er City	or Town St	ato Zir	Code	
Maryland	d 2 shoth and 7 lams			,, ,			-					10700		mymas	20,404.00	
	s 1 and 2 should be filed within 72 ho if Health and Mental Hygiene. Itam 27 Ia marked other than "natur other traumatic avent, Ira Madical		Patricia Morris / 20a. Method of Disposition	Sister	20b. F	Place of Dispo	sition (Nar	ne of			timore ate		rylan ocation - Ci			
Baltimore,	nt of nt of nt of r or o		1 Burial 2 Cremation 3		are	emetery, cre tro Cr	-				2006			,		a
Ë	ntme intani njury		4 ☐ Donation 5 ☐ Other (Special Sign are of Funeral Service Dise	11	rie			•			Derric					
Ba	permit. Pages 1 Department of H Important: If ital any injury or ott		21. Signal of Fulleral Service Lide	Cil							, Balt:					
			23a. Part1. Enter the disease, or com	plications that ca	used the deat										Approximat	
			shock, or heart failure. List only Immediate Cause (Final	one cause on ea	ch line.	011	. /	7			, , , , , , , , ,				Interval Bet Onset and I	
£':	Physician /Medical		disease or condition resulting in death)	a	nal	Cell		ne	son	nk						
	Examiner			o) of euc	ras a conseq	luerice or):										
1		e r	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (c	ras a consequ	usnea of):										
pt	uted d ansit	Examiner	Cause (Disease or injury that initiated events													
,	Attending Physician: The law requires that the death certificate be executed in death. To death. To death. To all this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Exa	resulting in death) Last	Due to (c	ras a conseq	quence of):										
8760,	ate be hysicia he bu	cai		_ d										_		
89	tifica ng ph as th	Physician/Medi	Is some													
Box	eath certific attending p for use as	an/A	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc	ome of pregnath 2 Peta		⊒Ectopic p	regnancy				- 1	23d. Date		*	
Θ.	deat ne att	100	in the past 12 months?		nt at time of c		Other (sp						Month	٦	Day `	Year
P.O.	at the de by the a	h	9 ☐ Unknown				-									
Ś	es tha igned be det		Part II. Other significant conditions	contributing to de	ath but not res		Indentying o	ause give	en in Part I	l. 7					he cause of o	
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ပ္ထ	law r as be 2 sh	Completed by	Hepalitis	C							24a. Was		24b. We	ere auto	psy findings	available
æ	The la	TO.	Om Tope	2							1 12 Yes	ormed? 2 □ N	de	ath?	2 No	
ā	ysician: The is certificate director, pag	Be	25. Was case referred t 'm dical examiner?						26. Place	e of Death	(Check only	one)				
>	Physic this ce al dire	2	1 ☐ Yes 2 V No	Hospital: 1 ☐ Ir	patient 2□	ER/Outpatie	nt 3 🗆 🗅 🗅 🗅	Oth Oth	er: 4 10 Ni	ursing Hor	me 5 ☐ Res	idence	6 Other	(Speci	fy)	
0	ding Ph h. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date o (Month	f Injury a, Day Year)	28b. Time of Injury	of 2	28c. Injur Wor	y at k?	2	28d. Describe	how inj	ary occurred	d		
Si.	ttendii death. stor: A / the fu	atic	2 ☐ Accident investigated				М	1 🗆	Yes 2	No						
Division of Vital Records,	r Att	Certification:	3 Suicide 6 Could not l 4 Homicide determined	286. Place	of Injury - At h g, etc. <i>(Speci</i>	ome, farm, st	reet, factor	y, office		2	28f. Location (City or To	Street a	nd Number le)	or Rur	al Route Num	nber.
D	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the			į.												
	tosp thou une ely fil	ca	(Check only 2 Medical Exa	hysician: To the miner: On the ba	best of my knows sis of examina	owledge, dea ation and/or in	th occurred	at the tin	ne, date ar pinion, dea	nd place, a	and due to the	cause(s) and mann	ner as s	tated. o the cause(s	5)
	the hin 2, the f	Medical	one)	and mann	er stated.											
	To To Poo	~	29b. Signature and title of certifier						e number	0			ate signed			
	1		7				4-1-7-	050	550	18		10	2-12	-0 (P	
	741		30. Name an address of person who		20		. Print)	2/1	4N 31	2000	D 21	1000	0			
	1		.000.0	Eaven	/SCA	- ,	DEL	am	020,	M	0 2	121	8			
	St Regist	ate rar	31. Date filed (Month, Day, Year) JAN 1 7 2006	183	gistrar's Sign	and and	18									

Maryland Virginia Mason-Buris
Baltimore, Maryland 21215-0036

		Please	Type or Print in Bla	ck Indelible Ink	. Ensure All	Copies Are	e Legible.	
		For 1 State	State of Maryland /	· · · · · · · · · · · · · · · · · · ·		ental Hygien	906	00756
		Registrar		Certificate of		Reg. N	lo.	
Physici		1. Decedent's Name (First, Middle, La. MARVI AND VIR		J-BURRIS		2. Date of Death Month Tonuary	Pay Year 12 2000	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give			or Location of Death		lc. County of Death	1.
		10495, M	ARLYN AVEN	UE Balt	imore		NA	
Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs. last	Months Days	If Under 24 Hrs. Hours Min.	B. Date of Birth (Month, Day, Yea	9. Birth Cor	place (State or Foreign intry)
Director		Usual Residence of Decedent	14	Yrs.		JULY05,1	931 M	TRYLAND
land ow		10a. State 10b. County	10c. City, To	own or Location				10d. Inside City Limits
Mary I-f sh	ţ	MARVIAND À)/4	BA17	-I MORE	CITU	/	1 XYes 2 ☐ No
th the or 284 e not	lrec	10e. Street and Number		10f. Zip Code		109.0	Citizen of What Co	ıntry?
burs after death with the Marylar al; or Items 23a or 28a-1 show	Funeral Director	10495.1	1ARLYN AVEN	IUE	2122		451	4.
ar dez	nue	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Spectan, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Amer Black, White	
rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 M No If Yes, Give Year or Dates:	1 ☐ Yes 2 🗷 No	Specify:		Specify: 12	MIN
	ted	15. Decedent's E	ducation 10	6a. Decedent's Usual Occu	pation	16b.	Kind of Business/l	ndustry
hin 7.	ple	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	(Give kind of work done life. DO NOT use retire	during most of working ad)	9		,
gien tha	Completed	12 HI GRADE		HOMER	1AKER	0		TOME
be fill d oth	Be	17. Father's Name (First, Middle, Last	3	2	18. Mother's Name	(First, Middle, Maid		
should be filed within nd Mental Hyglene. marked other than "	2	NATHANIE		RANCH	DERTH	A	WOOL	
C1 a 2 a		19a. Informant's Name/Relationship (SOU () ALIO UTE O)	9b. Mailing Address (Street	LING (WINDER OF HURAI	1. I (2)	y or rown, State, 2	n = 1 7 7 1
Health Health tem 27		20a. Method of Disposition	20b. Place	of Disposition (Name of	Da	ite 20c.	Location - City or	Town, State
Pages nent of I int: If it		1 Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Special	Hemoval from State	etery, crematory or other pla	' 1	1-06 B	AITIMA	EMA
permit. I Departm Importa any inju		21. Signature of Funeral Service Lice	nsee	PAR HILL (Em. 22. Name and Address	ess of Ficility 2/4	O North Fo	I HON AVE	we 21217
Departiment of the particular		in which I	1. Williams	Joseph H.	Brown, Jr.	Funeral H	one Bal	timore MD
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	iplications that caused the death. If one cause on each line.	Do not enter the mode of dyi	ing, such as cardiac or	respiratory arrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	netasta	tic Sma	ll Cell L	ung C	ancer	Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a consequent	ce of):		7		
	ē	Sequentially list conditions, if any, leading to immediate	b	ce of):				
uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events						
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	lical		d					
v requires that the death certificate been signed by the attending phys should be detached for use as the	Physician/Medic	IF FEMALE:	23c. If yes, outcome of pregnancy					
atten for us	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal de	ath 3 Ectopic pregnand	су		23d. Date of deli Month	very Day Year
the d	Jyst	1 □ Yes 2 ☑ No 9 □ Unknown	9 Unknown					
s that	by Pl	Part II. Other significant conditions	contributing to death but not resulting	ng in the underlying cause gr	ven in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
w require been signature should b						1 Pres	2 □ No 3 □ Pro	obably 4 Unknown
law ra as be 2 sh	Completed					24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
The The	Con					performed	death?	2 □ No
rician: Tician: Sertifical	Be	25. Was case referred to medical examiner?	Homital		26. Place of Death	(Check only one)		
Physi this c	<u>٦</u>	1 Yes 2 No 27. Manner of Death		And DOW		e 5 Residence		rify)
ding th. After	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury Wo	ork? Yes 2 No	BG. DOSCHDO HOW II	ijury occurred	
Atten deal octor	ertification;	3 Suicide 6 Could not b	28e. Place of Injury - At home	, farm, street, factory, office	2	8f. Location (Street		ral Route Number,
s afte	Cert	4 Homicide	building, etc. (Specify)			City or Town, St	are)	
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	edical (29a. Certifier 1 ertifying P	hysician: To the best of my knowle miner: On the basis of examination	dge, death occurred at the t	ime, date and place, a	nd due to the cause	(s) and manner as	stated,
the hin 24 the F	Medi	one)	and manner stated.		se number			
5 wit	-	29b. Signatura and title of certifier	= m.D.			0 Ja	Date signed (Month	12 2006
10		30. Name and address of person who	completed cause of death (Itom 21	Ra) (Type Print)			2 (1	
4		WYO WINCH	-0-) all 4 /al	Ba), (Type, Print)	Dremve:	#208,	5altime	me (h)
	ate	31. Date filed (Month, Day, Year)	32 Registrar's Signature					
Regist	rar	IAN 1 7 28	108 Alexand St	Anson C.				

			For State Registrar	State of Marylan			nt of Hea <i>te of De</i>		Mental H	ygiene Rag. No	Ullb	00757
	5 50	- 1 - 1 - 1	1. Decedent's Name (First, Middle, Last)						2. Date of D	eath Da	y Year	3. Time of Death
	Physicia /Medic	4.	Aryanna Isaline Ma	ason-Strange					Janua		1 2006	0 1845 M
	Examin		4a. Fecifity Name (If not institution, give s	treet and number)		4b. City	, Town, or Loc	cation of Death	7	4c.	County of Deatl	1
200			The Johns Hop	Kins Hospit		100	ultimo	ore (itu		N,	/ A
à	Funeral		Social Security Number 6. \$ex	7. Age (Irl yrs.	* .	If Unde		Under 24 Hrs. lours Min.		irth Day, Year)	9. Birth Co.	nplace (State or Foreign
	Director		N/A	M ZOJF	Yrs.		8		Jan .	3, 20		yland
	and *		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Loc	cation						10d. fnside City Limits
	sho	5					14-					1 ☐ Yes 2 🕅 No
	28a-f	Director	Maryland Anne Ar	under	AH	napo	IIS ip Code			10c Cit	izen of What Co	untry?
	with B or	ā	802 1/2 Highland	Διζεπιμε		101.2	21403			i og. o	USA	unity.
	eath	era		12. Was Decedent Ever in U	S. 13. W	Vas Dec		nic Origin? (S	pecify Yes or N	10-	14. Race - Ame	ncan Indian,
10	tied within 72 hours after death with the Maryland Hygiene. Other than "naturel", or iteme 23a or 28a-f show ont, the Medical Examiner must be multiped at	Funerai	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No	If	Yes, sp	ecify Cuban, M	lexican, Puert	o Rican, etc.)		Black, White	_
036	oi', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	∐ Yes	2X No S	pecity:			Specify: B	lack
21215-0036	72 ho	Completed	15. Decedent's Educ (Specify only highest grade				ual Occupation		rkına	16b. K	ind of Business/	Industry
21	thin 90.	pje	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	OO NOT	use retired)	ig most or no.	9			
7	ygier yer th	Co	0			N/				<u> </u>	N/A	
밀	tal H	Be	17. Father's Name (First, Middle, Last)				18.		ne (First, Midd		Sumame)	
<u>Ş</u>	ould Men varke	ပ္	Patrick Mason		T				Strang			
Maryland	12 sh and r tsr		19a. Informant's Name/Relationship (Ty)		4						or Town, State, 2	
e)	1 and Health em 2 ther 1		Sarah Strane, Mo	0.000	OUZ I			u Avenu	Date	+	ocation - City or	and 21403
آور	ages nt of nt of nt of		1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	emetery, crem		SATSUR THE	- 01	112106			
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel; or liteme 23s or 28s-f show any injury or other traumatic event, the Medical Examiliar must be mailed at an and once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service bicense		tro Cr				/13/06			Maryland
Ba	Dep imp		Thomas Gregor	Jun-		Cren	ation S	Society	Of Ma	rylar	d Inc.	and 21228
4	300		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the deat							:, Maryr	Approximate
	Dhusisian		Immediate Cause (Final									fnterval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Necro-tizw	Mance of)	ervo	01.4.5					1 day
	Examiner		## + PENERS WAY TO SEE CO	Premator	itu							& dous
	79	Jer	if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uen of):							
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events									
Ö,	e exe ian a urial-t		resulting in death) Last	Due to (or as a conseq	uence of):							
8760,	cate be executed physician and tha burial-transit	dicai		i							_	
9	e as	Mec	IF FEMALE:									
Вох	daath certific e attending p od for use as	an/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	fdeath 3 🗌		pregnancy				23d. Date of deli Month	very Day Year
	0 0	Physiclan/Me	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant at time of d 9□Unknown	eath 5⊡	Other (specify)					
P.O.	requires that the da reen signed by the a hould be datached t	P	Part II. Other significant conditions cor	ntributing to death but not res	ulting in the un	nderlyina	cause given in	n Part I.	23e. Dic	tobacco	use contribute to	the cause of death?
Vital Records,	8 60	d by	•			,	· ·		10	Yes 2	Mayo 3 □ Pr	obabiy 4 Unknown
Ö	> 0 0	ete							24a. Wt	s an	24h Were au	topsy findings available
Re	has has	Completed							aut per	opsy formed?	prior to death?	completion of cause of
ā	vician: Th certificate rector, pag	ပိ	25. Was case referred to medical				26	Blace of Do	1 ☐ Yes ath (Check only		1 ∐ Yes	2□ No
⋚	Physician: this certific ral director,	0 B	examiner?	lospital:	ER/Outpatien	t 3 🗆 [Othor				6 ☐Other (Spec	7.6.)
of	Phys er this eral di	-	27. Manner of Death	28a. Date of Injury	28b. Time of	. 00,	28c. fnjury at	7	28d. Describ			ony)
on	Attending r death. ector: After by tha fune	atio	1 SNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	М	Work? 1 ☐ Yes	2 🗆 No				
Division of	ar der ecto by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of fnjury - At h building, etc. (Special		eet, facto	ory, office			(Street ar		ıral Route Number,
Ö	tal or rs afte ai Dir	Cer		January, star (Special	,,						-/	
	o Hospital or Attenc 24 hours after death Funeral Director: stely filled in by that	edicai	(Check only 2 Medical Exami	sician: To the best of my kno nar: On the basis of examina	owledge, death	occurre	d at the time, o	date and place	e, and due to thur	e cause(s) and manner as d place, and due	stated. to the cause(s)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medi	29b. Signature and title of certifier	and manner stated.			9c. License nu				ite signed (Monti	
	70 T V			M. M.								
7			Cova Min	- John, W	- 00-1 7		0005	60%	2	Jan	Vary 11	2000
	\		30. Name and address of person who to AMIR-Lise J. Yo hay, 31. Date filed (Month, Day, Year) JAN 1 7 200	Min My 2 - 2 -	n 23a) (Type, l	erint)	Kar: L	60011	GAR AT INC.	160 St	Belts	MD 21200
544	Sta	ite.	31. Date filed (Month, Day, Year)	32. Registrar's Signa	gure /	1 6 E	TANNA	121100	000 10,001	.1/.	UNITIMA	1 1 1120 T
2	Regist		JAN 1 7 200	6 13 600 10	S. Carlotte	S. Line						

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** 2006 BURNEHA MURRAY 2:30 PM <u>01- 11-</u> /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner FOXHOUND RANDALLSTOWN COURT BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Hours Min. (Month, Day, 4/2) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Baltimore, MI 1□M 2**X**F Months 92 214-40-4317 Yrs. Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location Hygiene. other then "natural", or Items 23a or 28a-f show ent, the Mudical Examinat must be notified at MD Randallstown 1 ☐ Yes 2 No Director Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Foxhound Ct 21133 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black Baltimore, Maryland 21215-0036 Specify: þ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life_DO NOT use retired) 16b. Kind of Business/Industry City 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Educator Public Schools 12 of Health and Mental Hygis If Itam 27 is marked other or other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNK Be Pages 1 and 2 should be Husketh -OVey Joseph 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patterson, Daughte 4 Foxhound Ct. Randalls town, mo 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Metho of Disposition Babtimore, NO Burial 2 Cremation 3 Removal from State 1-16-06 ar butus permit. Page Depertment of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) e of Funeral Serv License 21. So the of Fune and Address of Facility cene Funeral Syts and Inc. South and Address of Facility cene Funeral Syts and Inc. South and Inc. Shock, or heart failure. List only one cause on each line. Randallstown, Mp 21133 Approximate Interval Between Onset and Death Immediate Cause (Final Physician DEMENTIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, nding physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) detached the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ HEART FAILURE CN GESTIVE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 D Onknown Certification: To Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2□ No 1 Tyes fo the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA within 24 hours after death.
To the Funeral Director: After thi
completely filled in by the funeral. 27. Manna Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28h Time of 28d. Describe how injury occurred Division 5 Pending 1 ☐ Yes 2 ☐ No М investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1. Certifying Physician: To the best of my knowledge death oncurred at the time data and plane, and due to the natise(s) and moner as stated 2. Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 2 Medical Exam 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 29c. License number 057722 M.D. JANUARY 14 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEONARD RICHARDSON M.D. 5602 BALTIMORE NATIONAL PILLE #663 BACTIMORE MP 21228 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

JAN 1 7 2006



State of Maryland / Department of Health and Mental Hygiene For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Dorothy Main Magner January 14, 2006 9:15 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner N/A Keswick MultiCare Center Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Aug 26, 19 Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 ☑ F Director 212-48-5204 Yrs Washington DC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Itam 27 is marked other than "natural", or Itams 23s or 28s-1 show 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Itam 27 is marked other than "natural", or Itams 23s or 28s-f show other traumatic avant. The McUlcal Exprending must be notified at KTYYes 2 No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 700 W. 40th Street 21211 USA by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Administrative worker Hopkins Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Estelle Zeigenheim Elwin Carr Main 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3925 Beech Avenue Apt. 319 Baltimore, MD 21211 Bernice Gail Magner Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ita any injury or ot ang. 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 1/18/2006 Metro Crematory Catonsville, MD * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Vicerises Burgee-Henss-Seitz Funeral Home, Inc. Sand. Enter the diverse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Argeny outonomers was Aresumed **Physician** disease or condition resulting in death) /Medical Due to (or as a con equal ce of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit has been signed by the attending physician and personal solutions are as the burial-transpector of the personal solution of the personal solution and personal solutions. Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Petal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ heart disease 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed this certificate 0651000 tive 1 ☐ Yes 280 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral E 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier (LUD) 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles St. Patte ald 21208 6/110 6701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#1, perMD, (851, 1/17/06 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar U6 Certificate of Death Reg. No. Merritt McCauley 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 8:10 R 10 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOPKINS BAYVIEW BALTIMORE BALTIMORE 5. Social Security Number 6. Sex f Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 11X3 M 2□ F 213-05-2662 Yrs. Director 25,1919 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Dundalk Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a United States 21222 8142 Del Haven Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Deperment of Health and Mental Hygiene. Important: if item 27 is marked other then "natural, or iten eny injury or other traumatic event, the Medical Enamina 1 Never Married 20 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🔀 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) United States Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Postal Clerk 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frances Mertz Merritt McCauley 19a. Informant's Name/Relationship (Type, Print) (Son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edgewood, Maryland 907 K. Woodbridge Ct. Mr. Merritt M. McCauley 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 1/13/2006 Someture of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Durdalk, Inc. 7922 Wise Ave. Dundalk, Maryland Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** EVERE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off. Examine The law requires that the death certificate be executed the attending physicien end thed for use es the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 ☐ Fetal death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) deteched 9 Unknown 9 Unknown page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Tes 2 VNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was autopsy performed? certificate hes 1 Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 2 ER/Outpatient 3 DOA After this 28a. I te of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2006 D0061358 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVENUE POTITIMORE, MD

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

2006

liller, Kegina 1-13-06 83-pm Baltimore, Maryland 21215-0036

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** REGINA MILLER January 2006 8:32 p.™ /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Gilchrist Center Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec. 12, 1929 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M 2□ F Yrs. Director 214-26-5194 76 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 27 is marked other then "natural", or iteme 23s or 28s-f show traumatic event, the Muchical Examinar must be notified at 1 √Yes 2 No Directo Maryland n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21212 U.S.A. 6010 Henderson Ave. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 1 No Specify: White 3 □Widowed 4 □ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 Waitress Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental Joseph Koscielski Agnes Cerino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Robert Miller (son) 1269 Walker Ave Baltimore, Maryland 21239 Department of Healt Important: if item 2: eny injury or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation ☐ Other (Specify) Green Mount Crematory 1-16-06 Baltimore, Md. Mitchell-wiedefeld F.H. inc. M00344 6500 York Road Baltimore, Md. 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final **Physician** cardiac disease or condition resulting in death) laes /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner anding physician and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certification: To Be Completed by rellation rapid 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Schother (Specify) HOSPICE Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending death. investigation 1 Yes 2 No within 24 hours after death To the Funeral Director: , completely filled in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) J25643

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

N. Charles

Street

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

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32. Registrar's Signature

Condoll Refaulknerma

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieria [] For State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Physician Monica Denise Maira January 2006 9:45a M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Towson Baltimore Gilchrist Hospice | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept 26 1943 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign PA **Funeral** 1 ☐ M 2 🂢 F 62 206-34-8872 Yrs Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28e-1 show other traumatic event, the Medical Examiner must be notified at Md Carroll Westminster 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 USA 1318 High Ridge Drive Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene. Int: If Item 27 ie marked other than "natural", or Iteme 23. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker domestic 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Pepon Celia Korman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1318 High Ridge Dr., Westminster, Md 21157 Louis Maira (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 Daurial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If eny injury or once. 1-14-06 All Saints Cem. Reisterstown, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityHaight Funeral Home & Chapel Dage Haight Herbert P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final alioblastoma **Physician** disease or condition resulting in death) 121R /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Medical Certification; To Be Completed by Physician/Medical use as the IF FEMALE. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. page 2 should be detached the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 2 XNo 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has autopsy performed? Yes 2 No certificate 1 🗆 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Ø No 1 | Inpatient 2 | ER/Outpatient 3 | DOA this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospitel or At within 24 hours after or To the Funeral Direct 4 \ Homicide Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

31. Date filed (Month, Day, Year) 2006 32. Pegistrar's Signature

N. Char

mpleted cause of Jeath (Item 23a) (Type, Print) 6701

5

Registrar

		1	1 - For State Registrar	State of Maryla		artment rtificate			and Mo		iene 006	00763
	Dhysici	20	1. Decedent's Name (First, Middle, Last)							2. Date of Deal Month	th Day Year	3. Time of Death
	Physici /Medic		Lillie R.	Myers						Jan.	13, 2006	11:00p M
	Examin	ner	 Facility Name (If not institution, give st 	reet and number)		4b. City, 1	Town, or	Location o	of Death		4c. County of Dea	th
-	ilja -	£	16111 Julie La 5. Social Security Number 6. Sex		s. last birthday)	La If Under	ure] If Under:	24 Hrs.	8 Date of Birth	Prince	George thplace (State or Foreign
	Funeral Director		10	м 2 V F 87		Months	Days	Hours	Min.	Month, Day,	7, 1918	thplace (State or Foreign ountry) MD
			215140215 Usual Residence of Decedent				1					
	how		10a. State 10b. County		City, Town or Lo							10d. Inside City Limits
	88-1 e	Director		George	Lauı							1 ☐ Yes 2 ☐XNo
	with th	a la	10e. Street and Number 16111 Julie Land			10f. Zip	207	0.7		1	0g. Citizen of What C USA	ountry?
	72 hours after death with the Maryland "natural", or items 23s or 28s-f show calcal Examinermust be notified at	Funeral		2. Was Decedent Ever in	115 13				gin? (Spe	cify Yes or No-	14. Race - Am	aocan Indian
10	fter d	Fun	11. Marital Status 1 Never Married 2 Married	Armed Forces?	0.3.	If Yes, spec	fy Cubar	n, Mexican	i, Puerto F	Rican, etc.)	Black, Whi	
036	ali, o	þ	3 □ Vidowed 4 □ Divorced	If Yes, Give Year or Dates:		1□Yes 2	X No	Specify:			Specify: [hite
5-0	72 ho natur	Completed	15. Decedent's Education (Specify only highest grade		16a. Dece	dent's Usua kind of wor	Occupa	tion	t of workin	a	16b. Kind of Business	/Industry
21	d within 72 ho piene. r than "natur Ine Medicel	ldu	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT us	e retired)			•	D	
12	14 14 ye		17. Father's Name (First, Middle, Last)	1		Home			r's Namo	/First Middle	Domest Maiden Sumame)	16
and	o d as D	Be		uhu Cr							meline Jo	nas
Maryland 21215-0036	d 2 should th and Mer 7 is marke traumatic	ပို	Irving Eli R 19a. Informant's Name/Relationship (Typ		19b. Maili	na Address	(Street a				r, City or Town, State.	
	nd 2 alth ar		Mr. David R. My		1.	-					MD 20707	
ē,	of Health item 27		20a. Method of Disposition	20b.	Place of Dispo	sition (Nam	ne of ther place)	Da	ate	20c. Location - City or	Town, State
E	Pages nent of int: if it		1	La La					1/17	7/2006	Sykesvil	le ,MD
Baltimore,	permit. Pages 'Department of Himportant: if ite any injury or ot once.		21. Signature of Funeral Service Licenses Suan C. Ho	with		Name and AIGHT					CHAPEL (E	
9			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the de	ath. Do not en	ter the mode	of dying	, such as	cardiac or			Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	_ End Stag	e Rena	al Di	Sea	80				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):							
п	- Xanniner	-	Sequentially list conditions b.	Azotemia		OOTIC	AC	laos	15			2 wks
	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Hyperten		leart	Di	seas	e			10 YRS
,	execunate and and ial-tra	Exal	that initiated events c. resulting in death) Last	Due to (or as a conse								
8760	the death certificate be executed y the ettending physician and iched for use as the burial-transit	dicall	d.	Diabetes	Melli	tus						25YRS
9	ng ph as th	dedi	IE EENAAL E.									
Вох	eath certific ettending p	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	ic. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe		DEctopic pre	egnancy				23d. Date of de Month	livery Day Year
	at the dea by the el tached fo	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at time of 9☐ Unknown	death 5	Other (spe	ecify)				Month	Day real
<u>α</u>			Part II. Other significant conditions cont	ributing to death but not re	esulting in the u	nderlying ca	ause nive	n in Part I		23e. Did to	bacco use contribute t	o the cause of death?
Vital Records,	Se G	d by	Advanced age				g., o			1 🗆 Y		robably 4 Dunknown
COL	w requir been si should	lete								24a. Was a	n 24h Were a	utopsy findings available
Re	The la	Completed			-				-	autops	sy prior to med? death?	completion of cause of
ta		0	25. Was case referred to medical					26. Place	of Death	1 ☐ Yes	-	s 2 No
	d is	To B	examiner?	ospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 DO.	A Othe				ence 6 Other (Spe	ecify)
n of			27. Manner of Death 1 ✓ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28	Bc. Injury Work	at	2	8d. Describe ho	ow injury occurred	
Sio	Attending r death. sctor: After by the fune	catle	2 Accident investigation			М		es 2 🗆 1	No			
Division		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, st cify)	reet, factory,	, office		2	8f. Location (Si City or Town	treet and Number or R n, State)	ural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical C	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examin	ician: To the best of my kier: On the basis of examinand marrier stated.	nowledge, deat nation and/or in	h occurred a vestigation,	at the time in my op	e, date an inion, dea	d place, a th occurre	nd due to the cod at the time, d	ause(s) and manner a late and place, and du	s stated. e to the cause(s)
	To the I within 2 To the I complet	W	29b. Signature and title of certifier	M		29c	. License	number		2	9d. Date signed (Mon	וֹה, Day, Year)
•	X		- Il Mari	1			>17	36	71		1-16	-04, 1
1	0 1		30. Name and address of person who con	mbleted cause of death (It	em 23a) (Type,	Print)		. 1		10 4	No 16-1	aciel
1	140		JK, Bachuby 31. Date filed (Month, Day, Year)	G(MAA) 32. Agistrar's Sig	RJUBI	9 17	146	16	NH	rong	IK TT	ud rus
	Sta Registi		JAN 1 7 200	W .	A. A	me						_

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Mary Carol Madero 9:10 AM JANUARY 14, 2006 /Medical 4c County of Death Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center Towson If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month Day, Year) 8/1/1943 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2⋤F 219-42-0978 62 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10a, State 10d. Inside City Limits *ohe Peges 1 end 2 should be filed within 72 hours after death with the Maryla nent of Heelth and Mental Hygiene.
ant: If Item 27 is marked other then "netural", or Iteme 23a or 28a-1 ehov ury or other treumatic event, the Madical Examiner must be notified at MD N/A Baltimore 1 ☐XYes 2 ☐ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3700 Ridgecroft Road 21206 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify ģ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager Telephone Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Wooden Virginia Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fred Madero/Son 3508 Rosekemp Avenue Baltimore, Maryland 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Peges
Depertment of I
Important: If Ite
eny Injury or of 1 Burial 2 Cremation 3 Removal from State Parkwood 1/18/06 Baltimore, Maryland 4 □Dofation 5 □ Other (Specify) re of Jun 11 S wice Licensee 21. Signa 22. Name and Address of Facility Miller-Dippel Funeral Home Inc. 6415 Belair Road Baltimore, Maryland 21206 ntl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ack, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition METASTATIC BREAST CANCER Physician /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ò Month Year Day signed by the a 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🖾 No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by SEPSIS 2 No 1 🗌 Yes 3 Probably 4 Unknown peeu 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? director, page 2 autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifice completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification; To 1X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 1X Certifying Physician: To the best of my knowledge, death decend at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 06 D 37254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER DRIVE. TOWSON. MARYLAND 21204 **7601** BOOM POH 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006

				For State Registrar		State of		and / De		nt of H	lealth and Death	•		06	0076	55
		Physici		1. Decedent's Name (William Wa		•						2. Date of D	Day	Jre C	3. Time o	of Death
		/Medic Examin		4a. Facility Name (If r	not institution, giv	e street and nu	ımber)		4b. Cit	, Town, o	r Location of Dea			ounty of Dea	ath	
				Baltimore						n Bu				ne Ar		
		Funeral		5. Social Security Nur 012-24-048		Sex 1⊊M 2□F	7. Age (In y	rs. last birtho Yr:	Month	Days	If Under 24 Hr Hours Mir		Birth Day, Year)	9. Bi	rthplace (State Country)	or Foreign
		Director		Usual Residence of D	0.1	Λ	/-2			1		09/1//	1931		NH	
		rylenc thow		10a. State MD	10b. County Anne Ar	mindol		City, Town							10d. Inside 0	·
1		Ba-f s	cto			. under	По	anover								s 2 🛣 No
111	7	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylend Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "neturel; or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinar must be notified at once.	by Funeral Director	10e. Street and Numb 7209 Fores						ip Code .076			10g. Citiz	en of What C US.		
MACTE		sr dee	uner	11. Marital Status		Armed F		U.S.	13. Was Dec	edent of F ecify Cub	lispanic Origin? (an, Mexican, Pue	Specify Yes or I	No- 1-	4. Race - Am Black, Wh	erican Indian, ite, etc.	
7	36	rs afte	oy Fi	1 Never Married 3 Widowed 4		1 X Yes If Yes, G	2□No ive Dates:1967	7_97	1 🗆 Yes	21 No	Specify:		5	Specify: Wh	ite	
2	9	2 hou eture cal E	ted		15. Decedent's Ed	ducation		16a. D	ecedent's Us	ual Occup	pation			d of Busines		
×	215	Phin 7:	Completed	(Specify Elementary/Second	y only highest gra dary (0-12)		1-4or 5+)		Give kind of v fe. DO NOT	rork done use retire	during most of w d)	orking				
	21	ygien ygien rt, the					1+	Avi	ation	Tech	nician				hington	Int'l
M	Maryland	ntal H ed oth	Be	17. Father's Name (F		")					Helen C	ame (First, Midd	le, Maiden S	Sumame)		
I ATM	Ž	should nd Me mark matic	2	19a. Informant's Nam		Type, Print)		19b. N	Mailing Addre	ss (Street	and Number or I		ber. City or	Town. State.	Zip Code)	
I,	N	nd 2 salth ar		Ruby Marte		*			_		ve., Har				_,p ====,	
=	J.	s 1 a		20a. Method of Dispo		75	201	p. Place of D	isposition (N	ame of other pla	ce)	Date	20c. Loc	ation - City o	r Town, State	
9	Ë	Page ment ant: M		1 ☐ Burial 2 ♥☐ 1 ☐ Donation 5	Other (Speci	JHemovai from fy)	State		remato	ry	01/1	6/2006	Cator	nsvill	e, MD	
_	Baltimore,	permit. Departimport any inj once.		21. Signature of Fund	eral Service Licer	nsee	M01378	3	Gary 1	And Address	ess of Facility an Funera ton Blvd.	l Home at	Meadowi	ridge Ma	morial P	ark, IV
		Physician /Medical Examiner	Examiner	23a. Pan1. Enter the shock, or heart Immediate Cause (£ disease or condition resulting in death) Sequentially list condition and the shock of any, leading to immediate. Enter Under Cause (Disease or in that initiated events resulting in death) La	ditions, nediate ying ajury	a. Due to	each line.	sequence of	ling		ng, such as cardi	ac or respiratory	arrest,		Approxima Interval Be Onset and	ite vitween I Death
	P.O. Box 68760,	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent ; in the past 12 m 1 Yes 2 Unknown	nonths? No	d	utcome of pre birth 2 F Inant at time on	gnancy etal death of death	3 □Ectopic 5 □ Other (specify) _				3d. Date of d	Day	Year
	ds,	signed The d	by	Part II. Other signific	ant conditions	contributing to o	death but not	resulting in t	ne underlying	cause giv	en in Part I.	238. Di	Yes 2		to the cause of Probably 4	
	Division of Vital Records,	The law requires ite has been sign age 2 should be	Completed									_ pe	as an topsy rformed	24b. Were a prior to death?	autopsy findings completion of	s available
	ital	ien: Trifical	BeC	25. Was case referre	ed to medical						26. Place of D	1 ☐ Yes eath (Check onl	/	1 □ Y∈	es 2 No	
	>	hysici his ce I direc	ToE	examiner?	No	Hospital:	Inpatient 2	2 ☐ ER/Outp	atient 3□ (OOA Ott	ner: 4 ☐ Nursing	Home 5 ☐ Re	sidence 6	□Other (Sp	ecify)	
	o uoi	inding Plath. r: After the funera		27. Magner of Death 1 Natural 2 Accident	5 Pending investigation		e of Injury nth, Day Year	28b. Tir Inji		28c. Injui Wo 1 🗀	ryat rk? ∣Yes 2 ∐No	28d. Describ	e how injury	occurred		
	Divis	al or Atte s after de sl Directo	Certification:	3 🗍 Suicide 4 🗌 Homicide	6 Could not be determined	286. Plac	e of Injury - A ding, etc. (Spe	t home, farn	n, street, fact	ory, office			(Street and own, State)	Number or F	Rural Route Nu	mber,
		To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medical (Certifying Pl	miner: On the	e best of my basis of exam nner stated.	knowledge, nination and/	death occurre or investigation	d at the ti	me, date and pla opinion, death oc	ce, and due to the	ne cause(s) a e, date and	and manner a place, and du	as stated. Je to the cause	(s)
		To th withir To th comp	Me	29b. Signature and ti	itle of certifier				2	9c. Licens	se number		29d. Date	signed (Mor	nth, Day, Year)	
		1		A.	atiR	iya	少.			D4:	3977		an	very /	3 200	2
	10	7		30. Name and addre	ss of person who	completed cau	use of death (Item 23a) (T	ype, Print)	. 1.	lan Br.		lo a A	210	1.1	
		St	ate	31. Date filed (Month	1, Day, Year)	32.	Registrar's 3	gnature	יואייני	100	un on	pare.	IVW	70	01	
		Regist			JAN1	2006	Mana.		1.	w.						

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** January 12, 2006 8:10 A M Nicholson, Jr. C. Paul. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 4100 North Charles St. unit 1113 Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1**∑**M 2□F Months Days Hours Min Yrs. Director 75 August 25,1930 Maryland 212-26-4699 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County or 28s-f show the Medical Examiner must be notified at 1 ¥ Yes 2 □ No Directo Baltimore N/A Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 238 4100 North Charles St. unit 1113 21218 USA death . Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 XYes 2 No ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed by 3 Widowed 4 Divorced White "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7:
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other then "se any injury or other traumatic event, Ite Music one. Elementary/Secondary (0-12) College (1-4or 5+) Construction Builder 10 n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lillian Easton Nicholson, Sr. T. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4100 N. Charles St., unit 1113, Baltimore, MD 21218 Joyce B. Rodgers/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jan 13, 2006 Catonsville, MD Metro Crematory 21. Signature of Funeral Service Li, ense 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093 23a. Part1. Env r the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate ause yinal disease or condition resulting in death) Chronic Obstructive Pulmonary Oseme Pnysician /Medical Due to (or as a consequence of) Examiner Antory Disease Coromany Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner Congestive ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760 by Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2□ No 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient Certification: To 1 ☐ Yes 2 XNo 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No To the Hospitel or Attend within 24 hours after death To the Funeral Director: A completely filled in by the fi 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 053156 on, swu au January 13, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar Jon E. Simon, M.D.

31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

2006

54 Scott Adam Road, suite 104, Cockeysville, MD

For	State of Maryland / Department of Health and Mental Hygiene	006	0071
State Regist Amend	Item #16a Per FH G851 1 /24/10/6 aut Death Reg. No.		007

/36	02	•	1 - State Regist Amend Item #1		aryland / Depa					G U U	6	007	167
			Decedent's Name (First, Middle, Last)	G0)1 1/24	/00~0	H1	-	2. Date of Dea	_		3. Time	of Death
	Physici /Medio		Dennis F. Neighb	ors					JANUAR)	$(14^{Day}, 20)$)06°	1004	. A M
	Examir		4a. Facility Name (If not institution, give 4707 OLD YORK ROA				Town, or	Location of Deat E	h	4c. County	of Death n/a	1.	
	Funeral Director		232-30-4700		e (In yrs. last birthday) 1 Yrs.	If Under Months		If Under 24 Hrs Hours Min.	8. Date of Birt (Month, Day Sept.	6 1934	9. Birth:	place (State ntry)	or Foreigr
	Maryland	tor	Usual Residence of Decedent 10a. State 10b. County MD n/a		10c. City, Town or Lo							10d. Inside 1 ☐ Ye	City Limits
	th with the 23a or 28	ai Director	10e. Street and Number 4707 Old York Ro	1.		10f. Zip		212		10g. Citizen of USA		ntry?	
5-0036	be filed within 72 hours after deeth with the Marylend tal Hyglene. d other then "naturel", or items 23a or 28e-i ehow event, ite Medical Examiner must be puilled at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 X Yes 2 1 1 Yes, Give Year or Dates:	Ever in U.S. 13.	Was Deced If Yes, spec 1 ☐ Yes		spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Rad Bla Specif	ck, White,	can Indian, etc. ack	
0-61212	within 72 ho lene. then "natur the Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		16a. Dece (Give life.	dent's Usua kind of wo DO NOT us	rk done d se retired	furing most of wo.)	rking	16b. Kind of B		dustry	
	Hygie ther ther ther ther ther		17. Father's Name (First, Middle, Last)	n/a	Cl	rief	Chef		ne (First, Middle,	Food P			
Maryland	d be f	o Be	Unknown by info	cmant					Beatrice				
<u> </u>	should by nd Menta marked	ဥ	19a. Informant's Name/Relationship (T)		19b. Mailie	ng Address	(Street a		ural Route Numbe			Code)	
	s 1 end 2 should f Heelth and Men Item 27 is marke other traumatic		Anna Peace/step-	daughter	1130	Elba	nk A	Ave., Ba	alto., MI	D 21239	,	,	
altimore,	Peges 1 enent of Hee		20a. Method of Disposition Burial 2 Cremation 3 4 Donation 5 Other (Specify)	Removal from State	20b. Place of Dispo cemetery, cree Garrison	sition (Nar matory or o	ne of ther plac	9) 1/2	Date 3/06	20c. Location			4D
Balt	permit. Peges Depertment of Important: If is eny injury or o		21. Signature of Funeral Service Licens Michael J. Blad) °	22	. Name ar	nd Addres	s of Facility	lome of	Owin Dulaney			Inc.
•	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused ne cause on each lir a. ARTERIOS	the death. Do not ent	er the mod	le of dying	, such as cardia	c or respiratory ar			Approxim Interval B Onset and	letween
68760,	icate be executed physicien and s the burial-transit	edical Examiner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	a consequence of):		-						
P.O. Box 68	death certif e ettending id for use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1∐Live birth 4∏Pregnant at 9∏ Unknown	2 Fetal death 3	Ectopic pr					te of delive	ery Day	Year
	quires that n signed b uld be dete	2	Part II. Other significant conditions co	ntribuling lo death b	ul not resulting in lhe u	nderlying c	ause give	n in Part I.		obacco use conl 'es 2 □ No		1	f death? Unknown
Division of Vital Records,	sicien: The law requires that the certificete hes been signed by th rector, page 2 should be deteche	Completed								an 24b. ssy rmed? 200 No	Were auto prior to co death? 1 Yes	psy finding mpletion of	s available cause of
ĭ Z	certificate	Be	25. Was case referred to medical examiner?	Hospital:			Othe	r	ath (Check only o				2.004
on of	ng Phys ther this	lon: To	27. Manner of Death Natural 5 Pending	28a. Date of Injui			28c. Injury Work	4 Iduising r	fome 5 ☐ Resid			y) SCEI	NE
Division		ertification;	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubulding, etc.	ury · At home, farm, str c. (Specify)				28f. Location (S City or Tow		er or Rura	al Route Nu	ımber,
_	To the Hospital or within 24 hours effe To the Funerel Dil completely filled in	edical C	7:0 Certifier 1 Certifying Phyone 1 X Medical Example 2 X Medical Example 2 X Medical Example 1 X Medical	ner: On the basis of and manner sta	of my knowledge, death examination and/or in ited.	h utcumed vestigation	at the tim , in my or	data and place sinion, death occu	I s, and due to the curred at the time, o	date and place,	and due to	lated. the cause	n(s)
	To the within To the Comp	Me	29b. Signature and title of certifier	1 /		290	: License		1	29d. Date signe			

441

State Registrar

29c. License number OCME

29d. Date signed (Month, Day, Year) JANUARY 15, 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 PENN STREET, BALTIMORE, MARYLAND, 21201

RJ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State of	Maryla	-	artmei <i>rtifica</i>			Mental H	ygiene Reg. No.	UUU	00768
H	Physici	an	1. Decedent's Name Curtis		black						2. Date of D Month Janua		Ĺ, 2006	3. Time of Death
>	/Medic		4a. Facility Name (If			ber)		4b. City	, Town, or	Location of Dea			County of Deat	4:50 p.™
			Southern 1		*				nton			Pr	cince Ge	eorge's
	Funeral Director		5. Social Security Nu 406-64-81 Usual Residence of	18 1	ex □xm 2□ F		. last birthday,	Months	Days	ff Under 24 Hi		7, 194	9. Birt Co Ker	hplace (State or Foreign untry) 1 TUCKY
	yland		10a. State	10b. County	*	10c. C	ity, Town or L	ocation						10d. Inside City Limits
	Be-fel	Funeral Director	CO	Jeffer	son		Broom					,		1 ☐ Yes 2 ☐ No
	with the core	Dire	10e. Street and Num	nber erald Str	reet				p Code 80020				zen of What Co	untry?
	deeth	nera	11. Marital Status	0. 414 00.	12. Was Deced		U.S. 13.			spanic Origin?	(Specify Yes or Norto Rican, etc.)		14. Race - Ame	
Maryland 21215-0036	be filed within 72 hours after deeth with the Maryland tall Hygiane. d other then "natural", or iteme 23a or 28e-f show event, the Medical Examinar most be notified at	ک	1 Never Marrie		Armed Ford 1 Yes 2 If Yes, Give Year or Da	No		1 ☐ Yes		Specity:	ano Hican, etc.)		Specify: W	e, etc. Nite
15-0 15-0	"natu	Completed	(Speci	15. Decedent's Ed fy only highest gra	lucation de completed)		(Give	edent's Usi e kind of w DO NOT	ork done d	uring most of w	orking	16b. Ki	nd of Business/	Industry
72	iane.	dmo	Elementary/Secon	ndary (0-12)	Coflege (1-	4or 5+)	1	Engir		,		En	ngineeri	ng Company
ğ	al Hyg I other	BeC	17. Father's Name (/							_	ame (First, Midd	e, Maiden		<u>g</u> p uy
<u>Ş</u>	should bind Ment	Po	Robert I							Anna	Carrol			
	1 and 2 sho Health and Iem 27 is mu		19a. Informant's Na Rita Nib	lack- Wit	Print)	los	1945	Eudo	ra St		enver, C	0 802	220	
Baltimore,	20 - 0			Scremation 3 C 5 Other (Specifi	1)	tate Hi		Servi	ce Co	orp. $1/$		Tows	cation - City or Son, Mar	yland
Ball	permit. Page Dapartment of Important: If eny Injury or once.		21. Signature of Fur	neral Service Licer		ther (eonard 3 Baltimo			
			23a. Part1. Enter th shock, or hear	ne disease, or com t faifure. List only	pfications that ca	used the dea							ai y i aiic	Approximate Interval Between
7	Physician /Medical		Immediate Cause (I disease or condition resulting in death)				cardiu	lm						Onset and Death
ı	Examiner		1000	(Due to (d	r as a conse		ut:	die	sectio	1-			
		ner	Sequentially list con if any, leading to im- cause. Enter Under	nditions, mediate	Due to (c	r as a conse		7100	Gr 3	secus	<u> </u>			
+	ecuted and transil	Examiner	Cause (Disease or inthat initiated events resulting in death) L	nfury	c									
8760,	icate be executed physicien and s the burial-transit	dical E	, , , , , , , , , , , , , , , , , , ,	l	d	or as a conse	iquence or):							
9	ertifica ling ph e as th	Medi	IF FEMALE:					-						
Division of Vital Records, P.O. Box	The law requires that the death certific to has been signed by the attending to egga 2 should be detached for use as	Physician/Me	23b. Was decedent in the past 12 r 1 Yes 2 9 Unknown	months?		th 2□Fe nt at time of	tal death 3	□Ectopic p □ Other (s					23d. Date of defi Month	ivery Day Year
٦.	s thet the	y Ph	Part II. Other signifi	cant conditions o	ontributing to de	ath but not re	sulting in the i	underlying	cause give	in in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?
rds	w requires their speed is been signed is should be det	ed b									10	Yes 2	X No 3□ Pr	obably 4 Unknown
eco	law re las be	Completed by									24a. Wa	opsy	24b. Were au	topsy findings available completion of cause of
<u>=</u>	n: The icate h										1 DY Yes	formed? 2 ☐ No	de th? 1 X Yes	
\frac{1}{5}	Physician: r this certifica ral director, p	To Be	25. Was case referrence examiner? 1X Yes 2 1		Hospital: 1 🗆 to	patient 2	S ER/Outpatie	ent 3 D	OA Othe		eath <i>Check</i> on Home 5 Re		2	
סר	o Phy ter this	n: T	27. Manner of Death	1	28a. Date o		28b. Time o		28c. Injury Work		28d. Describe			ary)
sior	Attending r death.	catic	2 Accident	5 Pending investigation 6 Could not be	1	,, ,	jury	М		res 2□No				
<u>D</u>	s after d	Certification:	4 Homicide	determined	28e. Place	of Injury - At g, etc. (Spec	home, farm, si cify)	treet, facto	ry, office		28f. Location City or T	(Street and own, State	d Number or Ru)	ral Route Number,
	To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, paga	Medical (29a. Certifier (Check only one)	1 Certifying Ph 2 Medical Exam	ysician: To the ninar: On the ba and mann	sis of examir	nowledge, dea nation and/or in	th occurred nvestigatio	d at the tim	e, date and pla inion, death oc	ce, and due to th curred at the time	e cause(s) , date and	and manner as place, and due	stated. to the cause(s)
)	To the To the Comp	W	29b. Signature and		, mis	>		29	OCM	number E		^{29d. Dat} Janua	ary 13,	1, Day, Year) 2006
	12		30. Name and addre				em 23a) (Type	, Print)	11 Pe	enn Str	eet Bal	timor	re, Mary	land 21201
9	Sta Registi		31. Date filed (Monta	n, pays year)		netlar's Sign	nature	Rain	27					
DH	MH 17 Rev 1/2	2001				September 1	30		-					

ORIGINAL

			For Stata Registrar		State	of Mar	yland / [it of H			ental Hy	gier Rag. R	UUU		0769	
П	Dhusisi	A.	1. Decedent's Name (First, M	iddle, Last	1)								2. Date of D Month		Day	Year	3. Time of Death	_
ı,	Physici /Medic		J	ensir	a Gunr	run 1	Nelson						Janua		9, 200		4:10 A M	
	Examin		4a. Facility Name (If not instit	ution, give	street and no	umber)			4b. City,	Town, or	Location	of Death		4	c. County o	f Death		
	W		2228 Searle	-		,				Dund							re Co.	
	Funeral		5. Social Security Number	6. Se	x ⊒M 2XTF		In yrs. last biri	thday) Yrs.	Months Months	1 Year Days	If Under Hours	Min.	B. Date of Bi (Month, D	rth ay, Yea	ir)	9. Birth	place (State or Foreign ntry)	
	Director		213-72-2373 Usual Residence of Deceden			7	5	TIS.					Jan. 4	,19	31	Ic	eland	
	land		10a. State 10b. Co			11	Oc. City, Towr	n or Lo	cation								I Od. Inside City Limits	-
	Mary i eh	Ď		- 1·						D		1 1_					1 ☐ Yes 2 ☑ No	
	28a	rec	Maryland 10e. Street and Number	ватт	imore				10f. Zip		unda.	LK		10g. C	Citizen of WI	nat Cou	ntry?	-
	3a o	Funeral Director	2228 Searle	e Poa	d						21	222			United	S+	ates	
	me 2	Jere	11. Marital Status	3 100	12. Was Dec	cedent Eve	er in U.S.	13. V	Vas Dece	dent of His			ify Yes or Nican, etc.)		14. Race	- Ameri	can Indian,	-
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturel', or Iteme 23e or 28e-f ehow any Injury or other traumatic event, I'm Muclical Exactional Le motified at anone.	by Fur	1 Never Married 2 ☐ 3 € Widowed 4 ☐ Divo		Armed F 1 ☐ Yes If Yes, G Year or I	2 No			Yes, spe		Specify:		ican, etc.)		Specify:	, White, Wh	etc. ite	
ŏ	2 hou	ted		dent's Edu			16a.	Deced	lent's Usu	al Occupa	ition			16b.	Kind of Bus			
212	hin 7.	Completed	(Specify only his Elementary/Secondary (0-			(1-4or 5+)		life. L	kind of wo DO NOT u	ork done d se retired)	lu <i>ring m</i> os)	st of working	9					
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	oth Vent	Be	17. Father's Name (First, Mic	dle, Last)							18. Moth	er's Name ((First, Middle	e, Maide	en Sumame)		
Maryland	should be to and Mental Is marked of umatic eve	2	Olafur Pal	son C	lafsso	n					Hel	ga Pal	lina S	igu:	rdardo	otti		
lan	sho and I		19a. Informant's Name/Relat						-				Route Numb				,	
	is 1 and 2. If Health at Item 27 is other trau		Mr. Helgi P.	Nels	on	(Son					il Be	erkele	ey Spr	ing	s, Wes	st V	irginia	
ore	of He		20a. Method of Disposition XXBurial 2 ☐ Cremat	on 3 🗀	Removal from		20b. Place of cemeter	Dispo y, cren	sition (Nai natory or o	me of other place	9)	Da	ite	20c.	Location - C	ity or To	own, State	
Ĕ	Pag ment ent: ury c		4 □Donation 5 □ Othe	r (Specify))		Sacre	d H	t. of	Jes	us Ç	em. 1,	/12/20	06	Dunda	alk,	Maryland	
Baltimore,	permit. Depart Import eny Inj		21. Signative of Funeral Ser	,	- ' la s	00-	>	22 D1	. Name ar uda – F	Ruck	s of Facili Fune:	ral Ho	ome of	Du	ndalk,		c. 222	
			23a. Part1. Enter the diseas shock, or hear failure.	e, or comp	lications that	caused th	e death. Do r	not ente	er the mod	de of dying	, such as	cardiac or	respiratory a	arrest,	,		Approximate Interval Between	-
	Physician		Immediate Cause (Final	List-only o			reat				nce						Onset and Death	
21	/Medical		disease or condition resulting in death)				consequence					X					o months	7
	Examiner		On the state of th	-	b													
	7 -	ner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	•	Duato	(or se sile	or sequence .	of):										_
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Ö,	e exe		resulting in death) Last		Due to	o (or as a c	onsequence	of):										
68760,	icate be executed physician and s the burial-transit	edical			d					_				_		-		
_	e as		IF FEMALE:											-				
). Box	that the death certif ed by the attending detached for use a	Physician/M	23b. Was decedent pregnan in the past 12 months? 1 ☐ Yes 2 2 No			birth 2 (nant at tim	pregnancy □Fetal death ne of death		Ectopic p Other (s _f						23d. Date Mont		ery Day Year	
P.O.	at the	Phy	9 Unknown	atal									00 0:4					_
of Vital Records,	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant cor	ditions co	onthouting to t	death but r	not resulting in	n the ur	naeriying o	ause give	n in Part	<u></u>					he cause of death? pably 4 Dunknown	
000	awre is be	Completed											24a. Wa:		24b. W	ere auto	psy findings available	_
ď	The lay ate has page 2	E O											auto	ormed?	de	ath?	mpletion of cause of 2 No	
ital	rtifica stor. p	Be C	25. Was case referred to me	dical							26. Place	e of Death ((Check only					-
_ <	Phyaician: The la r this certificate hav ral director, page 2	10	examiner? 1 ☐ Yes 2 No		Hospital: 1 □	Inpatient	2 ER/Ou	tpatien	t_ 3[] D0	DA Othe	9E 4□Ni	ursing Hom	e 5 Res	idence	6 Other	(Specif	y)	
0	ng PI fter th		27. Manner of Death 1 SNatural 5 □ Pe	ndina	28a. Date (Moi	of Injury	'ear) 28b. 1	Time of	1	28c. Injury Work	at	28	3d. Describe	how in	jury occurre	d		
Sio	endil eath. or: A	ati	2 ☐ Accident inv	estigation					М		res 2 🗆	No						
Division	Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific tely filled in by the funeral director.	Certification:		uld not be termined	286. Plac	e of Injury ding, etc. (- At home, fa Specify)	ırm, str	eet, factor	y, office		28	Bf. Location City or To			or Rura	al Route Number,	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral	edical C	29a. Certifier 1 Certifier 1 Certifier 2 Medianel	ifying Phy Icai Exam	mer: On the	e best of r	ny knowledge camination an	death	occurred estigation	at the tim	e, date ar pinion, dea	nd place, ar	nd due to the	cause , date a	(s) and man	ner as s	tated.	
	To the within 2 To the complet	Mec	29b. Signature and title of ce	rtifier	and mai	nner state	u.		29	c. License	number			29d. D	ate signed	(Month.	Dav. Year)	_
1	لا ∔≮ ⊣		Sinder	2	~~	PHY	SICIA	7			359	9			-		0,2006	
	9		30. Name and address of pe	son who c					Print) (1	_
1	5 Y		SYDIEN DY	UD	RM G			, , , ,		BA	LTIA	MORE	NADL	0 2	1205	-		
	Sta Registi		31. Date filed (Month, Pay,)	ear) 7 2	006 32	Registrar's	Signature				- 1 1/		,					
19.5	, region				345	No. Comment	-	4										

06-00306 Anthony 0'Dell

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	у о вел		1 - For State Registrar	State of Mar		artmen rtificat			ind M		Reg. No.	06	0077	10
	Physici	an	1. Decedent's Name (First, Middle, La.	st) Tyne O'Dell						2. Date of De Januar	y 12,	2006	3. Time of E)eath
	/Medio		4a. Facility Name (If not institution, giv.			4b. City.	Town, or	Location of	f Death	Januar		unty of Death	17.00	IVI
	Examin	er	125 West Brexton					more	Dogui			N/A		
	Funeral Director		5. Social Security Number 6. S		(In yrs. last birthday) 47 Yrs.	If Under Months		If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Aug	^{rth} 1958	9. Birth	place (State or ptry) Virgi	Foreign nia
	_		Usual Residence of Decedent								,			
	r 28a-f show	ច	10a. State 10b. County Maryland N/A	1	10c. City, Town or Lo	ocation altimo	nro						10d. Inside City 1 ∏ Yes	
	r 28a-	Directo	10e. Street and Number			10f. Zip					10g. Citizen	of What Cou	ntry?	
	23a o	alD	125 West Brextor	Road			21	L201			1	USA		
	er des	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Deced If Yes, spec	lent of Hi of Cuba	spanic Orig n, Mexican,	gin? (Spe , Puerto i	ecify Yes or No Rican, etc.)	o- 14.	Race - Ameri Black, White,		
Maryland 21215-0036	72 hours after death with the Maryland natural', or itama 23a or 28a-f ahow disal Ezaminar must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □ Yes 2 X No If Yes, Give Year or Dates:		1 ☐ Yes	2 ∑ No	Specify:			Spi	ecity: Wh	ite	
2-0	72 ho	Completed	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usua kind of wor	rk done a	urina most	of worki	ng	16b. Kind	of Business/In	dustry	
121	within ene.	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		во Not us Lght A						Airlin	26	
d 2	Hygi Ther Int.	0	17. Father's Name (First, Middle, Last)			LEITE I	10 001		r's Name	(First, Middle			=5	
ylar	Q 2 D .	To B	Rex W. O'Dell					Je	ean I	E. Marc	oney			
Man	s 1 and 2 should f Health and Mer item 27 is marks other traumatic		19a. Informant's Name/Relationship (Route Numb			Code)	
e,	Health item 27 other tre		Margaret O'Dell, 20a. Method of Disposition	Sibling	Rt.1 20b. Place of Dispo cemetery, crei					ve, Ohi		on - City or T	own. State	
JOE I	00		1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		Metro Cre				01/1	7/06		-	Maryla	nd
Baltimore,	permit. Pag Depertment Important: If any injury o		21. Signature of Funeral Service Like											
8	89 E 29		Thomas Gregor 23a. Part 1. Enter the disease, or com	y		299"E	rede	rick	Road	d Balt	imore	, Mary.	Land 21 Approximate	
8760,	Physician /Medical Examiner Strial-Itansit	ો Examiner	shock, or heart failure. List only timediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c		Care	lion	ras cu	ek i	dis	સફ્કૂ		Onset and De	∍ath
P.O. Box 687	The law requires that the death certificate be axeculed to has been signed by the attending physic as and lege 2 should be delached for use as the Sarial-Iransit	Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 montion 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live birth 2	Fetal death 3	Ectopic pr Other (sp					23d.	Date of delive	*	s ar
	w requires that been signed I should be det	þ	Part II. Other significant conditions of	contributing to deatr.	יים in the u	nderlying c	ause give	on in Part I.		23e. Did t	tobacco use o	contribute to t	he cause of de	
Division of Vital Records,		Completed										prior to co death?	psy findings av mpletion of cau 2 No	vailable use of
Vit.	Physicien: Th this certificate ral director, peg	Be	25. Was case referred to medical examiner?	Hospital:	-0-5%	-0-0	Othe			(Check only				
ou of	ding h. After fune	tlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day)	28b. Time o		8c. Injury Work	4 LINUI	2	ne 5 ☐ Resi 28d. Describe			SCENE	1
Divisi	i Pite	Certification;	3 Suicide 6 Could not b 4 Homicide determined	e One Diese etteine	y - At home, farm, sti (Specify)	reet, factory	, office		2	28f. Location (City or To		umber or Rura	al Route Numb	e <i>r</i> ,
	he Hospital n 24 hours he Funeral pletely filled	ledical (29a. Certifier (Check only one) Certifying Phase Addical Example (Check only one)	nysician: To the best of niner: On the basis of e and manner state	xamination and/or in	h occurred vestigation,	at the tim	e, date and pinion, deat	d place, a	and due to the ed at the time,	cause(s) and date and pla	d manner as s ce, and due to	tated. the cause(s)	
	To the within 2 To the comple	Ž	29b. Signature and title of certifier	0 41	2 ~	290	. License		,			gned (Month,		
	./		Calerie	las Al	1		υ.	C.M.E			Januar	y 13,	ZUU6 	
	5		30. Name and address of person who	completed cause of dea			Stre	et. R	alti	more,	Marvla	nd 212	01	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar	s Signature			-, 2		,			- -	
1	Registi	ar	JAN 1 7 200	C Real	H Rose	A 5								

State of Maryland / Department of Health and Mental Hygiepie | 1 - For State Registra Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Payne Martha 13 2006 12:40am /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Good Samaritian Hospital N.H. NA Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 10-25-10 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours 1 ☐ M 2 💢 F 95 Yrs. 129-18-5386 Director Va. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits , or itsms 23a or 28a-f show the Medical Examiner must be notified at Yes 2 No Director Md. NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21239 USA 1710 Sherwood Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after Hygiene. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black þ 3 X Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coffege (1-4or 5+) Laborer Clothing Factory Unkn 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be life Department of Health and Mental Hy Important: if Item 27 is marked oth any linjury or other traumatic avant 2002. Unkn Unkn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Neice 1710 Sherwood Avenue, Baltimore, Md. Margarette Page 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1√ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Mem. Pk. 1-17-06 Randallstown, Md. 21. Signature of Funeral Service Licensee 21202 22. Name and Address of Facility Baltimore, Md. e a y 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. March F.H. East Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ALZHEMER'S **Physician** DISEASE /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine led by the attending physicien and detached for use as the burial-transit be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day (Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? DEHYDRATION 24a. Was an performed? this certificete 20 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funerei Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Dentitying Physician: To the best of my knowledge death occurred at the time, data and place, and due to the cause(s) and it amends stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 128987 1-13-2006 on who completed cause of death (ftem 23a) (Type, Print) SPERLING, M.D. LOCH RAVON BLIP 5607 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

	Plea	se Type or	Print in	Black	ndelible	e Ink	Ensu	ire A	I Copies	Ar	e Legi	ble		
For			of Maryla								To	6	007	72
State Registrar					ertificat					Reg.	-			
1. Decedent's Name	(First, Middle	e, Last)							2. Date of De	ath			3. Time of	Death
Anne M.	Patro								Januar	у (5^{Day} 200) 6^{ear}	6:00	ам
4a. Facility Name (II	not institution	n, give street and no	umber)		4b. City,	Town, o	Location of	of Death			4c. County	of Deat	h	
Upper Ch	esapea	ke Medica	al Cent	er	Bel	Aiı	•				Han	rfor	d	
5. Social Security N 217-01-6		6. Sex 1 ☐ M 2 ☐ F	7. Age (In yr:	s. last birthda Yrs	Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da	y, Ye		Co	hplace (State o	or Foreign
			09	115					Feb. 26	,	1916	Mar	yland_	
Usual Residence of 10a, State	10b. County		10c. C	City, Town or	Location								10d. Inside C	h. Limite
Md.	Harfo		1.00.	,,	Bel Ai	r								2 □ No
					DC1 111									20110
10e. Street and Number						10f. Zip Code 10g. Citizen of What Country?								
518 Park Manor Circle					21014 U.S.A.									
11. Marital Status		12. Was De	cedent Ever in	U.S. 1	S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American In Black, White, etc.									
1 Never Marri	ed 2 Marr		2 No	1	1 Tes		Specify:		rinoari, oto.)			whi.		
3 ☐ ∦ Vidowed	4 Divorced	Year or	Dates:		1 🗆 105	ZALI NO	Specify:				Specify	/:WILL	LC	
(Spec		t's Education st grade completed)	16a. De (G	icedent's Usu ive kind of wo e. DO NOT u	al Occup	ation during mos	t of work	ing	16b	. Kind of B	usiness/	Industry	
Elementary/Secon	ndary (0-12)	College	(1-4or 5+)				1)							
10 years				hc	memake	er						hom	e	
17. Father's Name (First, Middle,	Last)					18. Mothe	r's Name	e (First, Middle	, Maio	den Suman	ne)		
Joseph F	'assio						Mar	iett	a Profi	li				
19a. Informant's Na	me/Relations	hip (Type, Print)		19b. Ma	ailing Address	(Street	and Numbe	er or Run	al Route Numb	er, Ci	ity or Town,	State, Z	Zip Code)	
Edward J	. Patr	o/son		211	.9 Hamp	ton	Court	t, Fa	allston	, I	4d. 21	L047		
20a. Method of Disp 1 Burial 2 (4 Donation	☐ Cremation	3 □Removal from	State	cemetery, c	sposition (National National N	other plac	. 1		Date 9/2006		Location -	•	Town, State	
21. Signature of Fu	neral Service	Licensee	-		22. Name ar	nd Addre	ss of Facilit	ty	Home o	f I	201 14		Tno	

Physician /Medical

1-1. D

Funeral Director

Be Completed by

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. important: If item 27 is markad other than "natural; or items 23a or 28a-f show any injury or other traumatic event, it e Medical Exeminer must be natified.

Baltimore, Maryland 21215-0036

Examiner

attending physician and for use as the burial-transit

signed by the a d be detached f

icete has been sig , page 2 should b

funeral director

filled in by

s efter death.
I Diractor: Af
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.

To the Funeral Diractor: After this certificate has been signed by the attending physician and

Division of Vital Records, P.O. Box 68760,

Be Completed by Physician/Medical Examiner

Certification: To

Medical

Immediate Cause (Final disease or condition resulting in death) Stroke with mass effect Due to (or as a consequence of): Right middle cerebral thromus of artery Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Untreated, undiagnosed hypertension Due to (or as a consequence of): IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line.

Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Month 23e. Did tobacco use contribute to the cause of death?

3 Probably 4 Unknown 1 ☐ Yes 2 No 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2√ No

21014

Approximate Interval Between Onset and Death

Approx.

days

	Vas case examiner?		to	medical
1	☐ Yes	2 No		
27. N	Aanner of	Death		

26. Place of Death Check on one Other: 1 Inpatient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury

1 Natural 5 Pending 2 Accident investigation 6 Could not be determined 3 Suicide

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

4 | Homicide

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

610 W. MacPhell Road, Bel Air, Md.

29b. Signature and title of certifier

29c. License number D0041080

29d. Date signed (Month, Day, Year)

Mmaag 30. Name and address of person w

completed cause of death (Item 23a) (Type, Print)

Jan 132006

State Registrar

Sood 940 Schucks Road, Bel Air, Md. 21015 Anuraag G. 31. Date filed (Month, 34, Year) 32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** January 10, 2006 0835 Dick D. Ponton ам /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harford Havre de Grace Harford Memorial Hospital 7. Age (In yrs. last birthday)
75 Yrs.

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Foreign March 12, 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 1930 | 19 5. Social Security Number **Funeral** 1₽M 2□F 229-34-9262 **Director** Usual Residence of Decedent 10b. County with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f ehow the Medical Examinist must be notified at 1√1Yes 2 No Harford Aberdeen Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21001 U.S.A. 700 W. Bel Air Avenue, Apt. 221 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐¥es 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married $_{\mathit{Specity}:}$ white 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: by 3 Widowed 4 Divorced "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) construction heavy equipment operator 11 years other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fill timent of Health and Mentai Hitent: If Item 27 is marked out Beatrice Brill Sale Ponton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 700 W. Bel Air Ave., Aberdeen, Md. 21001 Marie Ponton/wife 20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest VA Cem. 1/18/06

Date 20c. Location - City or Town, State Owings Mills, Md. 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Dapartment o Importent: If any injury or once. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. Defanio LoneRo 610 W. MacPhail Road, Bel Air, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MelANOMA Physician MALIGNANT 6 MONTHS /Medical Due to (or all a consequence of): **Examiner** S. pentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, Physician/Medical as been signed by the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. <u>ک</u> 3 Probably 4 Unknown 1 ☐ Yes 2 No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an this certificata 1 Yes 228 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation after death the 6 Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 5 To the Hospital within 24 hours at To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D32609 Whian 1/12/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Revolution St. Haure de Grace, Mo MithANI, MD KAM RUDIN 1106 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

3

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Robert L. Porter, Sr. January 14 2006 1:02 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park
If Under 1 Year | If Under 24 Hrs. Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1⊠M 2□F Yrs. Director 577-44-1143 71 1934 Washington, DC Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other then "naturel", or Items 23a or 28a-f show traumatic event, the Mudical Examinar must be notified at 1 ☐ Yes 2 X No Director Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8601 Montpelier Drive 20708 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1X Yes 2 □ No If Yes, Give Year or Dates: t Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 □Widowed 4 □Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Elevator Mechanic Union 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental H lant: If item 27 is marked out Edwin G. Porter Margaret Echols 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Porter/Wife 8601 Montpelier Drive, Laurel, MD 20708 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 0 permit. Page Department of Important: If eny Injury or ance. West Arundel Crem. 1/16/2006 4 ☐ Donation 5 ☐ Other (Specify) Odenton, MD 22. Name and Address of Facility Donaldson Funeral HOme, P.A. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or learn failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA 313 Talbott Avenue, Laurel, MD 20707 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner MULTIPLE MYELOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-fransit physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? t ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death be detached 9 Unknown 9 Unknown δ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CORONARY ARTERY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To completely filled in by the funeral 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 XNatural 5 Pending s affer death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral [Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD0057800 1114106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HSHRAF 7600 Carroll Avenue, Takoma Park, MD MUHAMMAD 32 Aegistrar's Signature 31. Date filed (Month, Day, Year) Some? State 2006 France So Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Vear **Physician** EVELYN PARADIS 5:15 AN 2006 JAN 5 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NIH ILL HAVEN ANELPHI PRINCE (SCORGES If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex **Funeral** 1□ M 2**X** F 508 16 5080 85 Director NEBRASKA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f ehow traumatic event, the Medical Examinar must be notified at 1 Yes 2 □ No PRINCE GEORGES Director BOELPHI mo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code)SA 3210 POWDER MILL ROAD 20783 Itame 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 ò 1 ☐ Yes 2 🛣 No Specify: Specify: White ₩idowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 15 POSTAL ie marked other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Clerk SERVICE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental 8 AGNES MAL 2 ose 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) in and 2 st of Health ar 54Keville ma 21784 SON 636 TANGLEWOOD DEIVE 100V VAN CLEVE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Department of important: If it eny injury or o Winfield, MO 17/2006 South Canal Crematery JNZUMBOUN FHAMONCO. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 21784 ELDERS BURG MO 6028 SYKESVILLE ROOM 23a. Part 1. Enter the disease, or com shock, or heart failure. List only Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MAO **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Þ Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. been signed by the should be detached 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 10 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has breath 1□ Yes 2 110 or Attending Physician: 25. Was case referred to medical director. Be 26. Place of Death (Check only one) Hospital: 1 Inpatient examiner? Other: 1 Yes 2 No 4 Hursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA this After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Watural 5 Pending 1 ☐ Yes 2 ☐ No death. thin 24 hours after death.

the Funaral Director: A mpletely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dey, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0801 LOCEW900 LOBYN D. ANDERSON 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2006

Registrar

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			For State Registrar	State of Maryland		rtment of H <i>lificate of L</i>			(No.	00776
Í	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al		V. Pitts				January	16,200	
	Examin	er	4a. Facility Name (If not institution, give s			4b. City, Town, or			4c. County of Dea	
	Funeral		728 Bowleys Qua 5. Social Security Number 6. Sex		ast birthday)	If Under 1 Year	ys Quar If Under 24 Hrs.	8. Date of Birth	Baltimo 9. Bir	thplace (State or Foreign
	Director		238-24-0542]M 25⊈F 8	5 Yrs.	Months Days	Hours Min.	(Month, Day, Y Jan 15	, 1921Nor	thCarolina
	pur &		Usual Residence of Decedent 10a. State 10b. County	10c City	, Town or Loc	ation				10d. Inside City Limits
	Manylé f aho	ō	MD Baltimo			s Quart	ora			1 Tes 2 The
	28a-	Director	10e. Street and Number	,10	Owież	10f. Zip Code	CIP	100	. Citizen of What Co	ountry?
	th with		728 Bowleys Qu	arters Road		21220			USA	·
	u within 72 hours after death with the Maryland ilon. ilon. then natural; or items 23s or 28s-1 show the Madical Examinational be notified at	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. W	as Decedent of His Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
20	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:		□Yes 2⊠No	Specify:		Specify: Wh	
215-0036	thour stural		15. Decedent's Edu	cation	16a. Decede	ent's Usual Occupa	ation	16	b. Kind of Business	
<u>ლ</u>	within 72 ene. than "nat	piet	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	life. D	O NOT use retired)	fu <i>ring m</i> ost of work)	ing		
N	filed wit Hygiene ther the	Completed	10th	,	Homen		· · · · · · · · · · · · · · · · · · ·		wn home	
Maryland	e d ala	Be	17. Father's Name (First, Middle, Last)	7.7 lo				e (First, Middle, Ma		
Ĕ	d 2 should the and Ment it and Ment it is marked traumatic e	ဥ	Roy Milton 19a. Informant's Name/Relationship (Ty	,	19h Mailine	Address (Street a		y Garris	SON Dity or Town, State, .	Zin Codo)
2	75 - 7		Gerald Graham	so, r fing					nd NC 27	
ē,		1	20a. Method of Disposition		ace of Dispos	ition (Name of atory or other place			c. Location - City or	
Ē	permit. Pages Department of I Important: If its any injury or of once.		1 ☐ Burial 2 ☐ Cremation 3 🔀 F 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State G16	enwood	Memoria	al //	9/06 M	looresvi	lle NC
Baitimore,	srmit.		21. Signature of Funeral Service Licens	3e /	1 22.	Name and Addres	s of Facility	nnellvFi	ineral Ho	meofEssex
	40 E E 9	03	M. Jury	Connel	ly:	300 Mac	e Ave.	Baltimor	ce MD 21	221
	· *		23a. Part1. Enter the disease, or combine shock, or heart failure. List only or Immediate Cause (Final	the cause on each line.	Dornot ente	r the mode of dying	g, such as cardiac	or respiratory arrest	t,	Approximate Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequ	eas	T CO	incer			year
	Examiner			Due to (or as a consequence)	1/22	0100	1 M	etast	757	1 year
	₽ #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ience of):	O/ Con	1	CHALOV.		J
	ecute end -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ		· · · · · · · · · · · · · · · · · · ·				
Ď,	ificate be executed g physicien end as the burial-transit	aiE		Due to (or as a consequ	ierice or).					
98/89	ificate g phys as the	edicai								
ROX	at the death certifu I by the ettending parached for use as	Physician/M	230. Was decedent pregnant	3c. If yes, outcome of pregnar		Ectopic pregnancy			23d. Date of de	livery
	e deat	sicia	in the past 12 months?	4 Pregnant at time of de		Other (specify)			Month	Day Year
J.	requires that the een signed by thi nould be detache	Phy	9 ☐ Unknown Part II. Other significant conditions cor		dting in the un-	dashina anyan saya	en in One I	22a Did taha		o the cause of death?
g,	signe d be c	1 by	A A A A A A A A A A A A A A A A A A A	a belon	inting in the uni	o il. 7	en in Part I.	1 ☐ Yes	_	robably 4 Unknown
000	- D 76	lete		CO CO		L GUV		24a. Was an		
Vital Hecords,	sicien: The law certificate has b irector, page 2 si	Completed						autopsy performe	prior to death?	utopsy findings available completion of cause of
ta	(D)	0	25. Was case referred to medical				26. Place of Deat	1 Yes 2. h Check only one	No 1 Yes	3 2 □ No
	Physicie this cert al direct	To B	examiner? 1 Yes 2 No	lospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatient	3 DOA Othe			ce 6 ⊟Other (Spe	ecify)
Division of	ding Ph h. After th funeral		27. Mann eath 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Tim <i>e</i> of Injury	28c. Injury Work	at	28d. Describe how		
<u>s</u>	death death stor: /	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho	ma form stra		fes 2 □ No	29f Location (Stro	at and Alumbas as C	and Boute March
<u>></u>	after Direct	Certification:	4 ☐ Homicide determined	building, etc. (Specify)	et, ractory, onice		City or Town,	et and Number or R State)	urar Houte Number,
	Hospitel or Attending Physicien: 24 hours after death. Funeral Director: After this certific tely filled in by the funeral director.		29a. Certifier 4 Certifying Physics	sician: To the best of my know	wledge, death	occurred at the tim	e, date and place,	and due to the cau	se(s) and manner as	s stated.
	fo the Hos within 24 h fo the Fur completely	Medical	(Check only 2 Medical Exami one)	ner: On the basis of examinat and manner stated.	ion and/or invi	estigation, in my op	oinion, death occur	red at the time, date	and place, and due	e to the cause(s)
	To the To the	2	29b. Signature and title of certifier	0		29c. License	_		Date signed (Mont	th, Day, Year)
1	7	11	74-6			K	3550	13	111.6	2000
	6		30. Name and address of rson who co	impleted cause of death (Item	23a) (Type, F	-4M	ace A	10 R	e Atrain	ore MB
120	Sta	ite	31. Date filed (Month, Day, Year)	32. Redistrar's Signat	ture	P. 10 2	· VV	~, ~	7 1419	21221

State Registrar 31. Date filed (Month, Day, Year) JAN 1 7 2005

JC Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a,27,pen/E,G851,1/19/06 TI State of Maryland / Department of Health and Mental Hygiene () () 06-00243 Certificate of Death Paul Price 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year Paul Joseph Price 22:03 P M January 09,2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 817 8th Street Apt. 104 Prince George's Laurel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1⊠M 2□F Yrs Director 264-68-1624 61 29, 1944 Connecticut Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 te marked other than "natural", or Items 23a or 28a-f show any Injury or other treumatic event, the Medical Examinar must be notified at once. Director 1 Yes 2 No Prince George Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 817 8th Street Apt. 104 20707 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ∑Yes 2 □ No IfYes, Give Year or Dates: 1963-67 Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 XNo 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) U.S. Government/ Elementary/Secondary (0-12) College (1-4or 5+) National Security Agenty Language Analyst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Woodrow Price 2 Henrietta Talbot 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Wright /spouse 9733 Quiet Brook Lane, Clinton, Maryland 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State W. Arundel Crematory Jan 17, 06 4 □ Donation 5 □ Other (Specify) Odenton, Maryland 21. Signaturé of Funeral Service Li - nsee 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed nding physicien and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 XNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1. Yes 2□ No 24a. Was an autopsy performed? 1 Yes 2□No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Scene 1XXes 2□No 2 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 5 Pending death. investigation 1 ☐ Yes 2 ☐ No Director: A 2 ☐ Accident Divisi 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours efter To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and tylle of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 10, 2006 30. Name and address of person who completed quse of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 7 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 6:00 P M William Phillips Joe January 8,2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Dundalk Baltimore 7575 Westfield Road If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1⊠M 2□F Director 52 25,1953 Maryland 215-60-0699 Aug. Usual Residence of Decedent with the Maryland *ohe 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f ebov traumatic event, the Modical Examinar must be notified at Director Dundalk 1 ☐ Yes 2 X No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7575 Westfield Road 21222 United States death Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 20 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CSX Railroad Years Machinist/Engineer pelij 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be I Department of Health and Mental I Important: If Item 27 Is marked o Nelva Jenna Smith Verus D. Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Jacquelyn K. Phillips 7575 Westfield Road Dundalk, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State ö 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 1/12/2006 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 'n 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death, shock, or hear failure. List only one cause on each line. Anot enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a cr sequence of Examiner transit The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician a Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 | Fetal death 3 Ectopic pregnancy in the past 12 move 1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) P.O. the be detached 9 Unknown s contributing to death buy ot resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Š 1 | Yes 2 | No 3 Probably 4 □Unknown Completed page 2 should peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed Division of Vital 1 Yes 2 410 1 Tyes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Other: 1 Yes 2 🗆 🗸 1 🗌 Inpatient ျှ 2 ER/Outpatient 4 Nursing Home 5 Residence 6 □Other (Specify) 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the completely On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check on 29b. Signature and tille of certifier 29c. Deense number 29d. Date signed (Month, Day, Year 00 3a) (Type, P 31. Date filed (Month, Day, State 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 🖺 🖺 🖯 Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death JANUARY 14, 2006 **Physician** PRISTOOP РМ HILDA 9:15 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WOODHOLME SPRINGS ASSISTED LIVING PIKESVILLE BALTIMORE If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) MAR. 17, 1914 Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 □ F 216-01-2609 Director RUSSIA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State ral', or items 23s or 28s-f show Examiner must be rectified at 1 ☐ Yes 2 ☐ No Director BALTIMORE PIKESVILLE the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21208 101 WOODHOLME AVENUE USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify WHITE 3 ☐ Widowed 4 ☐ Divorced "natural" and Mental Hygiene.
is marked other than "naturaumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) TRANSCRIBER U.S. GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **ABRAHAM** PRISTOOP FANNIE MOLOFSKY ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: if item 27 is any injury or other trau once. 3 SHADYWOODS COURT - OWINGS MILLS, MD 21117 ALLAN PRISTOOP / NEPHEW 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) MOSES MONTEFIORE CEM | 01/15/2006 HALETHORPE, MD 21. Signature of Fundial Service Ligensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Dementic /Medical Due to (or as a consequence of): Examiner Ceremul Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Attending Physicien: The law requires that the death certificate be executed use as the burial-transit P.O. Box 68760/0 Due to (or as a consequence of) physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown ra-lune life on L 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Hyperfunce autopsy performed? certificate 1 Yes 2 No after death.

Director: After this certific
I in by the funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 ther (Specify) 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27 Manner of Death 28b Time of 28c. Injury at Work? 5 Pending 1. Natural 1 ☐ Yes 2 ☐ No м investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide ō Hospitel pel : 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) 029085 o se JUNUARY 15 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. 5310 Allen 31. Date filed (Month, Day, Year) 32. pgistrar's Signature State Registrar

David I. Perell Unpend item#23a,27, pend 1,0852,2/1/06 H. Ensure All Copies Are Legible. 06-00305 State of Maryland / Department of Health and Mental Hygiene NJM For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** DAVID Ι. PERELL 2006 1433 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 664 Kennington Road Reisterstown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth JUN. 8,1948 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 □ F 57 Yrs Director 203-40-6921 PA Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23s or 28s-f show nings must be notified at 1 ☐ Yes 2 ☑ No MD BALTIMORE REISTERSTOWN Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 664 KENNINGTON ROAD 21136 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. WHITE ð Specify: 3 ☐ Widowed 4 💢 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify onfy highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) AUTOMOTIVE REPAIRMAN AUTOMOTIVE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental **PERCHIK** ABRAHAM PERELL FAY ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .00 Department of Heelth a Important: If Item 27 is eny injury or other tres SANDRA GOLDEN / SISTER 664 KENNINGTON ROAD - REISTERSTOWN, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CARROLL CREMATION INC. 1/15/2006 4 ☐ Donation 5 ☐ Other (Specify) HAMPSTEAD, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Hypertensive Atherosclerotic Cardiovascular Disease /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 4 Unknown 1 ☐ Yes 2 ☐ No Completed 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No Be 25. Was case referred to medical 26. Place of Death Check only one examiner' Hospital: 1 | Inpatient Yes 2 □ No Other: 4 \square Nursing Home 5 \square Residence 6XXXOther (Specify) Scene ၉ 2 ER/Outpatient 3 DOA his 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending To the nospiral within 24 hours after death.

To the Funeral Director; Af 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year)

JAN 1 7 2008

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Agents

OCME

111 Penn Street

January, 13, 2006

Baltimore, Maryland 21201

State

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2006 Margaret E. Poe January 10 4:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chesapeake Woods Center Cambridge Dorchester If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 ☐ M 2√2 F Director 217-10-8575 04/04/1916 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location itam 27 is marked other than "natural", or Itams 23a or 28e-f show other traumatic event, the Medical Examples at 10d. Inside City Limits Prince Georges 1 TYPYYes 2 □ No Director MD Beltsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11601 Ash Road 20705 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry of Health and Mental Hygiene, itam 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Printer Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be Floyd Smith Ruth Edwards ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If itam 27 is Ronald Hurley / Son P.O. Box 1508 Laurel, MD 20725 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any injury or once. ö Meadowridge Memorial Park | 01/13/06 Elkridge, MD * 4 ☐ Donation 5 ☐ Other (Specify) permit. 22. Name and Address of Facility
Cary L. Kautman Funeral Home at Meadowridge Mamorial Park, INC MO1378 7250 Washington Blvd, Elkridge, MD and Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, flock, or heart failure. List only one cause on each line. M01378 7250 Washington Blvd, Elkridge , MD 21075 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 404 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. attending physician IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) the detached Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 90 1 ☐ Yes 2 ☐ 3 ☐ Probably 4 ☐ Unknown MASCA Be Completed funeral director, page 2 should certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 200 1 🗌 Yes 1 TYAS Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 10 1 Yes Certification: To After this Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending death. 1 Tyes 2 No 2 Accident investigation after death 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2 06 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who 100 .00 RR 31. Date illed Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiepen n Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** BRIDA RAMSAY 9:55 PM JOAN 2006 January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Baltimore Washington Medical 5. Social Security Number 6. Sex 7. Age (Arundel Glen Center Burnie If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 29,1936 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign
Country) **Funeral** Days 1 M 2 F Ohio 69 Director 219-30-6323 Usual Residence of Decedent 10d. fnside City Limits 10a, State 10c. City, Town or Location wode item 27 is marked other then "netural", or iteme 23s or 28s-f ebov other traumatic event, the Mudical Examinar must be notified at 1 Yes 2 No Glen Burnie Directo Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21060 U.S.A. 7721 Norfolk Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 M No ff Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 I No Specify: Specify: White þ ff Yes, Give Year or Dates: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) Coilege (1-4or 5+) Social Sec. Admin. 12 0 Administrative Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emma E. Lodwick 2 C. Lilly James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Important: if item 27 is any injury or other trau once. 7719 Norfolk Road, Glen Burnie, Maryland 21060 (Son) Steven L. Ramsay 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Lakeview/Mem Park 01-19-06 Sykesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 Ann Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one/cause on each line. Heart tarluve diate Cause (Finat Congestive Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner LOW Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine or Attending Physician; The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 Yes 2 No ate has been signed by the a page 2 should be detached for P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 4 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an rmed? 2 No certificate 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes, 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of fnjury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending fnjury i Director: Aff d in by the fur 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical within 24 hou To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MMD January 14. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 Hospital Drive, Glen Burnie, Wicks Jeorge

DHMH 17 Rev 1/2001

State Registrar 31. Date fifed (Month, Day, Year)

2006

32. Registrar's Signature

Decedent's Name (First, Middle, Last)

For State Registrar

Certificate of Death

3. Time of Death

Reg. No.

2. Date of Death

IANUARY

Month **Physician** 13, January 2006 3:05 A. <u>Ann Marie Rosenberger</u> /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore County Stella Maris Hospice Timonium If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 🖸 F Yrs. 80 **Director** 220-12-9818 March 01,1925 Philadelphia,PA Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show traumatic event, the Madical Examiner must be notified a 1 ☐ Yes 2X No Director Maryland Baltimore County Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Iteme 23a 207 Eastspring Road 21093 United States Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 Never Married 2 Married ò 1 Yes 2000 Specify: Specify: White 3 Widowed 4 □ Divorced "naturel" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Home Maker 80 Own Home n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be nent of Heelth end Mental end Mental Mary Tufano Jerry Iacarino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Heelth e Mrs. Sharon A. Matcuk (Daughter) 207 Eastspring Road Timonium, Maryland or othar 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny Injury or once. Evans Funeral Chapel Jan. 13, 2006 | Forest Hill, Maryland 4 □ Donation 5 □ Other (Specify) Peaceful Alternatives Funeral&Cremation 2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service Licensee Ctr.,P.A. 2323 TOTA ROAU TIMOTITUM, Frait of 2323 TOTA ROAU T Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CHRONIC OBSTRUCTED PULMONARY DISEASE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner sicien and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Be Completed by Physician/Medical igned by the attending phys be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 1 Yes 2□ No 2 No 1 Yes or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 10 Other (Specify) HOSPICE 1 Yes 2 No Certification: To 3 DOA his 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural Injury 5 Pending after death.

Director: Af
d in by the fur investigation t ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Symminer: On the basis of examination and/or investigation in manner as stated. 29a. Certifier Medical completely (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 13/06 13726 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) h DR. TARIO MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) Registrar

> . **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 6 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Marcia Lee Rogers January 12, 2006 7:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1026 Glen Villa Drive Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Morth, Day, Year) April 6, 1954 Maryland 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕅 F Months Days Hours 51 Yrs. 218-68-5526 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location woye 10a. State 10b. County 10d. Inside City Limits item 27 is marked other then "netural", or iteme 23s or 28s-1 ebox other traumatic event, the Mudical Examitian marke notified at 1 ☐ Yes 2 No Director Anne Arundel Glen Burnie Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1026 Glen Villa Drive 21061 USA Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: if Item 27 is marked other then "netursi", or Ite 1∑ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎇 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Cashier Retail 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kenneth E. Rogers Helen Reed 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John W. Rogers, Brother 726 S. Pine Street Red Lion, <u>PA 17356</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: if ite eny injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc. 4 ☐ Donation 5 ☐ Other (Specify) 01/13/06 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Cremation Society Of Maryland Inc. 299 Frederick Road Baltimore, Maryland 21228 Thomas Gregor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiagous respiratory an est, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Adenocarcuros Priysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Completed by Physician/Medical the th as USB 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant aften for u 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 Yes 2 No 1 Yes 3 No Division of Vital To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this cartifical completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) $D\mathcal{R}$

State Registrar

DHMH 17 Rev 1/2001

1105 31. Date filed (Month, Day, Year)
JAN 1 7 200

2006

32. Registrar's Signature

		1	For State Registrar	State of M	aryland /		artment of H rtificate of L		d Me		giene Reg. No.	6 (078	5
	Physici	an	Decedent's Name (First, Middle, La.	st)					2.	Date of Dea Month	ath Day	Year	3. Time of I	
	/Medic			J. Russ			# 05 T	Leaving of D		01-	14-	06	1127	1a M
	Examin	er	4a. Facility Name (If not institution, give Franklin Saware	-1	Carbo	-	4b. City, Town, or	1 /	eatn		180	nty of Death	ore	
	Funeral		5. Social Security Number 6. S	Hospital Sex 7. Ag	ge (In yrs. last i	birthday)	If Under 1 Year	dale If Under 24 I	Hrs. 8.	Date of Birti (Month, Day		9. Birth	place (State or	Foreign
40	Director		216-04-5417	1 □ M 2 □ X E	64	Yrs.	Months Days	Hours A		Ian28		Mar	yland	
-	D 3		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	ocation					-	10d. Inside City	y Limits
	the Marylan 28a-f ehow	ō	MD Baltim	ore			sex						1 🗌 Yes	
	28a-	rect	10e. Street and Number				10f. Zip Code				10g. Citizen	of What Cou	intry?	
	23a of	ai D	1735 Hilltop	Ave.			212	21			USA			
	eme	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin' n, Mexican, P	? (Specification of the control of t	y Yes or No-	14. F	lace - Amer		
9	s afte	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ If Yes, Give	No		1 ☐ Yes 2 ☐ No	Specify:					ite	
1.Ne	filed within 72 hours after death with the Maryland Hygiene. Hygiene they filed within 'natural', or items 23s or 28s-f show ent, the Maryleal Examiner must be natified at	ed b	15. Decedent's E	Year or Dates:	16	Sa. Dece	dent's Usual Occupa	ation			16b. Kind of			
9 E	hin 72 Mars in	piet	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4or		(Give life.	kind of work done of DO NOT use retired	furing most of)	working				,	
7 5	filed with Hygiene. other ther	Completed	8th		3.7	Hom	emaker				own !			
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Maryland	should be ind Mental marked c	င္	Maurice Bees 19a. Informant's Name/Relationship ((Type Bright)	1	Ob. Maili	ng Address (Street a			Hade		m Ctnto 7	in Codol	
USSell,	s 1 and 2 should be filed Health and Mental Hyg Item 27 le marked othe other traumatic event,	3	Jackie Reavis				35 Hill:							
ي کي ق	s 1 and 2 f Health Item 27 other tra		20a. Method of Disposition		20b. Place	of Dispo	osition (Name of matory or other place		Dat	- T	20c. Locatio			
12USS	Pages nent of I int: If Its		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special				enCemet		/19/	06	Balt	imore	MD	
	permit. Pag Department Important: I eny Injury o		21. Signature of Funeral Service Lice	nsee D	.00	2:	2. Name and Addres						meofEs	ssex
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	prications that cause	d the death.	not en						FID Z	Approximate Interval Betw	1000
	Physician		Immediate Cause (Final disease or condition	^		~U -I	a luce.						Onset and D	eath
	/Medical		resulting in death)	Due to (or at	a consequent	of):	failure						73/1/	/ ///
	Examiner	L	Sequentially list conditions,	b. Carc	inom	iar	flung							
•	ted 1sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):										
-	be executed sicien and burial-transit	Exar	that initiated events resulting in death) Last	c. Due to (or as	s a consequen	ce of):								
09289 208	ate be hysicie he bur	Icai	· · ·	_ d										
ď	ng ph as th		IF FEMALE:											
Š	leath certifica	an/Med	23b. Was decedent pregnant in the past 12 months?		2 Fetal dea	ath 3[☐Ectopic pregnancy					Date of deli Month	,	ear
0	The color day, I	ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant a 9∐ Unknown	at time of death	5[Other (specify)						,	ou.
	res that the de igned by the c	y Physi	Part II. Other significant conditions	contributing to death	but not resultin	g in the u	ınderlying cause give	en in Part I.		23e. Did to	obacco use c	ontribute to	the cause of de	eath?
7	quires n sign uld be	ed by							_	1 🚭	res 2 No	3 □ Pro	obably 4 🗀 U	nknown
9	aw require	piet								24a. Was		b. Were au	topsy findings a	vailable
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3	ystcian: The is certificate his director, page	Be	25. Was case referred to medical examiner?					26. Place of	Death (Check only o				
4	Physic this or	2	1 ☐ Yes 2 ☐ No	Hospital: Inpat				4 🗀 1401511			dence 6 🗆		eify)	
	ding Ph h. After th funeral	ion:	27. Manneyof Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inj (Month, D	ay Year) 28	b. Time o Injury	Worl	yat k? Yes 2∐No		d. Describe I	now injury oc	curred		
objection of Witch	or Attending Physician: after death. Director: After this certific in by the funeral director.	ficat	3 ☐ Suicide 6 ☐ Could not I	be 300 Blace of Is	njury - At home	, farm, st	reet, factory, office	.63 2	28			m <i>ber</i> or Ru	ral Route Numt	::
č	al or safter	Certification:	4 Homicide	building, e	etc. (Specify)					City or To	vn, State)			
	To the Hospital or Attent within 24 hours after dealt To the Funeral Director: completely filled in by the	edicai (29a. Certifier 1 Certifying P (Check only 2 Medical Exa	Physician: To the besiminer: On the basis and manners	of examination	dge, dea and/or ir	th occurred at the tin	ne, date and p pinion, death	olace, an	d due to the at the time,	cause(s) and date and place	manner as ce, and due	stated. to the cause(s)	
	To th within To th compl	Me	29b. Signature and title of certifier	(O 1	0.5		29c. Licens				29d. Date sig			
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-	4		30. Name and address of person who	completed cause of	death (Item 23	a) (Type	, Print)	287 rive B	, /		, /	10 -	-	
	Service Co.		31. Date filed (Month, Day, Year)	uja 9000	trank/	11 59	ware D	rive B	a/h	mire	Md 2	163%	7	
	St Regist	ate rar	JAN 1 7	2006	CAR A	9 1	ander							

			1 - For State of Maryland / Departmen Certificate Certificate	t of Health and Me e of Death	ental Hygien	1000 001	86
	.		Decedent's Name (First/Middle, Last)		2. Date of Death	ay Year 3. Time of	Death
	Physicia /Medic	_	LOBERT Richard	con .		15 2006 12:3	4 A ^M
	Examin	er		Town, or Location of Death	4	c. County of Death	
			5. Social Security Number 6. Sex. 7. Age (In yrs. last birthday) If Under	imore 1 Year If Under 24 Hrs. 8	8. Date of Birth	N/A 9. Birthplace (State of	r Foreign
ŀ	Funeral Director		218-94-5897 17 M 20 F 26 Yrs. Months	Days Hours Min.	8. Date of Birth (Month, Day, Yea	979 marya	nd
	p .		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				111-14-
	f ahov	ŭ		ti mano		10d. Inside Cit	
	28a-1	Director	10e. Street and Number	Code	10g. C	itizen of What Country?	
	3a or			21218		USA	
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent Ever in U.S. If Yes, spec	dent of Hispanic Origin? (Spec offy Cuban, Mexican, Puerto R	cify Yes or No-	14. Race - American Indian,	
21215-0036	be filed within 72 hours after death with the Maryland itel Hygiane. A other than "natural", or Itama 23e or 28a-f ahow avent, the Medical Examiner must be instilled at avent, the Medical Examiner must be instilled at	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give 1 ☐ Yes		ican, etc.)	Black, White, etc. Specify: Black	2
5-0	72 h	etec	15. Decedent's Education 16a. Decedent's Usus (Specify only highest grade completed) (Give kind of wo	rk done during most of working	g 16b.	Kind of Business/Industry	
121	within 72 ane. than "nai	Completed	Elementary/Secondary (0·12) College (1-4or 5+)	se retired)	R	esturant	
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lan		To Be	Robert D. Richard Son	Ther	esa	walker	,
Maryland	d 2 should th and Mer 7 is marks traumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address	(Street and Number or Rural	Route Number, City	or Town, State, Zip Code)	
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Baltimore	es of it		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Nancemetery, crematory or o	me of Da	1 101	Location - City or Town, State	
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Bal	permit. Departr Imports any Inju		Jewel / raich cary	+	real Thon	e Balto, mb, 2	1229
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mod shock or heart failure. List only one cause on each line.		p-9	Approximate Interval Betwoonset and E	ween
	Physician (Madical		Immediate Cause (Final disease in condition resulting in death) BLUNT FORC	E INJU	RIES	Offiser and E	2 0 4111
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	:	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
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8760,	ate be hysici the bu	dicai	d				
9	n certific anding p use as	/Med	IF FEMALE:				
Вох	eath certific ettending p for use as	ian	23b. Was decedent pregnant in the past 12 months? 1			23d. Date of delivery Month Day Y	/ear
P.O.	The law requires that the death certific ste has been signed by the ettending p bage 2 should be detached for use as	Physician/Med	1 Yes 2 No 9 Unknown 9 Unknown	ecily)			
	res that igned b be deta			ause given in Part I.	23e. Did tobacco	use contribute to the cause of d	leath?
rds	w requires been sig should b	ed b			1 ☐ Yes	2 ¹ ∕2 ² No 3 □ Probably 4 □ U	Jnknown
of Vital Records,	e law re has bee	Completed by			24a. Was an autopsy	24b. Were autopsy findings a prior to completion of ca	available
Ĕ		Com			performed?	death?	au5e 0i
/ita	ician: Tector, p	Be (25. Was case referred to medical examiner?	26. Ptace of Death	(Check only one)		
of	Physician: this certific ral director,	2				6 ☐Other (Specify)	
	ding After fune	tion	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 1 1 4 06 15:30 PM	28c. Injury at Work? 1 ☐ Yes 2 No	Bd. Describe how inj	ary occurred	2
Division	Attendition of death.	fica	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Ptace of Injury. At home, farm, street, factory		Bf. Location (Street a	and Number or Rural Route Numi	ber. i
á	ai or A s aftar ii Dire	Certification;	4 Stomicide determined building, etc. (Specify)	11	City or Town, Sta	1800 Blockw L. Baltimore Ch	MST
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune			at the time, date and place, ar	nd due to the cause/	s) and manner as stated)
	thin 2 that c	Medical	one) and manner stated. 29b. Signature and title of certifier 1 29c	c. License number		ate signed (Month, Day, Year)	
	E ₹ 8		Les All A ~ M	OCME			
7	7		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	OCFIE	Jar	uary 15, 2006	
				1 Penn Street	Baltimor	e, Maryland 212	201
	Sta	ate	31. Date filed (Month, Day, Year) 32 Registrar's Signature				
	Regist	rar	JAN 1 7 2006 Jan & Jack				
DH	IMH 17 Rev 1/2	001					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 7'.15 pM Raymond is 2006 Leroy Robey Jr. ANVATY /Medical 4b. City, Town, or Location of Death Anne Arunde 4a. Facility Name (If not institution, give street and number) Examiner 105 Chalmers Auc If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 11 M 2□ F 76 Director 220-24-1070 9-25-1929 MD Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f ehow traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 No Director Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. or Iteme 23a 105 Chalmers Ave. 21061 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 Yes 2 No permit Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. I hoportant: if them 27 is marked other than "natural", or fler any injury or other traumatic event 1 Never Married 2 Married White 1 ☐ Yes 2ΩXNo Specify: þ 3- Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Field Engineer Electronic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Raymond L. Robey, Sr. Lena Pearl Hamer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Mark William Robey / son 163 Dundee Road; Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 1-19-2006 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial Elkridge, MD 21. Jign ture of Funeral Service Licenses 22. Name and Address of Facility Singleton Funeral Home, PA 1 Second Ave SW; Glen Burnie, MD 21061 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Dra Immediate Cause (Final disease or condition resulting in death) mutastatic (arcinoma at **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: NA 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown Pag II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ate has been signipage 2 should be 2 🗆 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes No 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital c within 24 hours af To the Funeral D completely filled in

law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 or Attending Physician:

Baltimore, Maryland 21215-0036

6

Medical

29a. Certifier

(Check only

29b. Signature and

30. Name and address of person

one)

State Registrar

32. Registrar's Signature 31. Date filed (Month,

2 Medical Examiner

tle/of certifier

29c. License number
0 0022463

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

January 16,2006

death (Item 23a) (Type, Print) is all of Burnie, MD 2106

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

	1.	Registrar Decedent's Name (First, Middle	, Last)				O OI L	Death	2	. Date of Dea			3. Time of Death
sician edical	l.	Rebecca	Su	e		F	Reed			Month 1-12-	-200	y Year 6	8:04P
iner	48	a. Facility Name (If not institution,		∍r)		4b. City,	Town, or	Location of [eath			County of Dea	ath
Ą		7133 B&A B1vd					n Bu					Anne Ar	
	L	Social Security Number 288-72-8983	6. Sex 7. 1 ☐ M 2 ♣ F	Age (In yrs.	(ast birthday) Yrs.	If Under Months		If Under 24 Hours	Min. 9	Date of Birtl (Month, Day -20-19	Year)	9. 8i	rthplace (State or Foreig Jountry) Germany
	-	sual Residence of Decedent 0a. State 10b. County		10c. Cit	ty, Town or Lo	cation		-					10d. Inside City Limit
ō		MD Anne	e Arundel		len Bu								1 ☐ Yes 21 N
Director	1-	0e. Street and Number			TOIL DO	10f. Zip	Code				10g. Cit	izen of What C	country?
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ပိ	1	7. Father's Name (First, Middle,	2		waiti	ess		18 Mother's	Name /	First, Middle,		Hospita	Піту
To Be		Terry Siebert			-			Sandr	,		walu u r.	(Sumame)	
	1	19a. Informant's Name/Relations	, , , , , , , , , , , , , , , , , , , ,									or Town, State,	Zip Code)
	_	Scott Reed /] Oa. Method of Disposition	Husband	20h F	713 Place of Disp			d; Gle	n Bu	rnie,		21061 ocation - City o	r Town State
	1	1 🖾 Burial 2 ☐ Cremation		ate C	cemetery, cre	matory or o	ther place						
	L	4 □ Donation 5 □ Other (S) 21. Signature of Funeral Service			ocust					2006		hester, eral Ho	
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Jer		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, rany, leading to immediate cause. Enter Underlying Lause (Disease or injury	a. Due to (or	as a consequence as a consequence		Bro	ain	tur	V.				Interval Between Onset and Death
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	1 - For State Registrer 1. Decedent's Name (First, Middle, Last)	State of Marylan	d / Depa		lealth and		ene 06	00789
Physician /Medical Examiner	Bruce R. Rhodes 4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Dea	Jan. 12	Day Year 2006 4c. County of Death	3. Time of Death 2:15 A M
Funeral Director	5. Social Security Number 6. Sex 288-30-6144 X Usual Residence of Decedent	7. Age (In yrs.	last birthday) Yrs.	Timonis If Under 1 Year Months Days	If Under 24 Hr Hours Min		Baltimore year) 9. Birth Cou 1937 Ohio	place (State or Foreigr intry)
death with the Maryland me 23a or 28e-f ehow roust be notified at neeral Director	10a. State 10b. County		y, Town or Loc	eysville	-			10d. Inside City Limits 1 ☐ Yes 2 X No
urs after	4 Queensbridge 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Ct. Apt. C 12. Was Decedent Ever in U. Armed Forces? 1 DY'es 2 No If Yes, Give Year or Dates: 60'-	1		030 lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	USA 14. Race - Ameri Black, White,	can Indian,
ed within 72 hor ygiene. her then "natura it, the Medical E	15. Decedent's Edu (Specify only highest grade	cation	16a. Deced	ent's Usual Occup kind of work done OO NOT use retired	during most of we	orking	16b. Kind of Business/Ir	ndustry
should be filed nd Mental Hygia marked other umatic event, III	17. Father's Name (First, Middle, Last)			•	Coletta	M. Kilba	faiden Sumame)	
permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury or other traumatic eny injury or other traumatic eny injury or other traumatic eny injury or other traumatic eny injury or other traumatic eny injury or other traumatic eny injury or other traumatic eny injury or other traumatic eny injury or other traumatic eny injury or other traumatic eny injury or other traumatic eny injury or other traumatic eny injury or other traumatic eny injury or other traumatic eny injury or other traumatic eny injury or other traumatic eny injury or other traumatic end injury or other end injury or other traumatic end injury or other end injury or other end injury or other end injury or other end injury or other end injury or other end injury or other end injury or other end injury or other end injury or other end injury or other e	Mary Rhodes/wife 20a. Method of Disposition 1	emoval from State Di cations that caused the deat	Place of Disposementary, cran Llaney 22 10 h. Do not ente	stion (Name of natory or other pla Valley M Name and Addre emmon F W. Pad	lemorial ss of Facility uneral Fonia Rd	16/06 Gardens Home of D	Cockeysville Coc. Location - City or T Timonium, ulaney Val um, MD 21(own, State
res that the death certificate be executed igned by the attending physicien and be detached for use as the burial transit by Drysician/Medical Examin	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Due to (or as a consequence of the consequence of t	ancy Il death 3 [leath 5 [Ectopic pregnanc Other (specify)			23d. Date of deliv Month	ery Day Year
he law requires the has been signer age 2 should be d	Part II. Other significant conditions cor	ntributing to death but not res	ulting in the ur	nderlying cause gn	ren in Part I.		24b. Were auto prior to co death?	bably 4 X Unknow opsy findings available ompletion of cause of
certificat rector, p	25. Was case referred to medical					eath (Check only one	20-31	
r Attending Phyer to death. Irector: After this hy the funeral dis	1 162 2 10	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At houlding, etc. (Specif	ER/Outpatien 28b. Time of Injury ome, farm, stre	28c. Injui		28d. Describe ho	eet and Number or Run	
	29a Certifier 1X Certifying Phy	sician: To the hest of my knows: On the basis of examina and manner stated.	owledga death ation and/or inv	r secured at the hi	me, date and plac opinion, death occ	te, and due to the da curred at the time, da	use(s) and manner as the and place, and due to	tated. o the cause(s)
To Within	29b. Signature and title of certifier 30. Name and address of person who or	moleted cause of death //tor	n 23a) (Type		e number	25	9d. Date signed (Month,	
State	DR. TARIQ MAHMOO		EY VALI		TIMONIUM	4, MD 2109	3	

DHMH 17 Rev 1/2001

JANUARY 12, 2006 2:15 a.m.

BRUCE RHODES

	Physicia /Medic Examin	an al er
	Funeral Director	
Baltimore, Maryland 21215-0036	permil. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heelth and Mental Hygiene. Importent: if Item 27 is marked other then "natural", or Iteme 23a or 28a-f ehow any Injury or other treumatic event, the Medical Examinar must be notified all page.	To Re Completed by Funeral Director

Physician /Medical Examiner

To the Hospital or Attending Physicien: The law requires thet the deeth certificate be executed within 24 hours efter death.

To the Funerel Director: Atter this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Division of Vital Records, P.O. Box 68760,

-	_ For	epartment of Health and M Certificate of Death	Mental Hygien	UUU.	00790
	1. Decedent's Name (First, Middle, Last)		2. Date of Death	V	3. Time of Death
an i	Mary L. Rosier		JANUARY 1	ay _{Үөаг} 5, 2006	12:03 AM
al er	4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center	4b. City, Town, or Location of Death	4	c. County of Death	imore
	5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Months Davs Hours Min.	8. Date of Birth (Month, Oay, Yea	9. Birth	place (State or Foreign ntry)
	215-26-9144 TS TS TS TS TS TS TS TS TS TS TS TS TS	S.	May 12,		ID
	10a. State 10b. County 10c. City, Town of	or Location			10d. Inside City Limits
to	MD Carroll	Sykesville		{	1 □Yes 2 □No
Je C	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Cou	intry?
	943D Marimich Court	21784		US	י א
era	11 Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp	pecify Yes or No-	14. Race - Ameri	can Indian,
Fu	1 Never Married 2 Married 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto	Hican, etc.)	Black, White	
Completed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: Wh	ite
ted	15. Decedent's Education 16a. D (Specify only highest grade completed)	ecedent's Usual Occupation Give kind of work done during most of work	king 16b.	Kind of Business/Ir	ndustry
npie	Elementary/Secondary (0-12) College (1-4or 5+)	ife. DO NOT use retired)		ealth Ca	ro
င်	11	Nurse			116
Be	17. Father's Name (First, Middle, Last)	18. Mothers Nam	ne (First, Middle, Maide	en Surname)	
၉	C. Edward McDonald		Margaret		- 0-4-1
	Lac es	Mailing Address (Street and Number or Rui			
	Mr. Louis E. Rosier (Spouse) 20a. Method of Disposition 20b. Place of Disposition	943D Marinich Ct.	Sykesv	ille M	D 21784
	1X Burial 2 ☐ Cremation 3 ☐ Removal from State	, crematory or other place)			
		View Mem. Park 1	/18/06 Sy	kesvill	e, MD
	21. Signature of Funeral Service Licensee/	HAIGHT FUNERAL			
	23a. Part1. Enter the disease, or complications that caused the death. Do no	Sykesville, MD on the other states of the state of Sykes and the mode of dying, such as cardiac	21784 (41 or respiratory arrest,	0) - 795	1400 Approximate
	shock, or heart failure. List only one cause on each line. Immediate Cause (Final	a may and d			Interval Between Onset and Death
	disease or condition resulting in death) a. ACUTE MYDCARI Due to (or as a consequence of	VIAL INFARCTION			
	CORONARY ARTE				
ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of				
Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events c. RENAL FAILURE	Nga se			
Exa	resulting in death) Last Due to (or as a consequence of				
cai	d				
edi					
Ž	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death	3 Ectopic pregnancy		23d. Date of deli	,
Sicie	1 Yes 2 Tho	5 Other (specify)		Month	Day Year
Physician/Medical	9 Li Unknow#	ale and the second section is a second	22a Did tahasa	a una contributa ta	the cause of death?
þ	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	1 ☐ Yes		10
eted	RESPIRATORY FAILURE			T	
Completed by	LACTIC ACIDOSIS		24a. Was an autopsy performed	24b. Were aut prior to death?	topsy findings available ompletion of cause of
			performed	No 1 ☐ Yes	2 No
Be	25. Was case referred to medical examiner? Hospital: The second of the	Other	ath (Check only one)	a [] 211 (2)	
2	27. Manner of Death 28a. Date of Injury 28b. Ti	patient 3 DOA 4 Nursing H	lome 5 Residence 28d. Describe how in		ary)
tion		me of 28c. Injury at 28c/Work? M 1 Yes 2 No			
fica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, far	m, street, factory, office	28f. Location (Street		ral Route Number,
Cert	4 Homicide determined building, efc. (Specify)		City or Town, St	are)	
Medical Certification:	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.				
Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month	n, Day, Year)
	Richard L. Lythieux	D 31826		-15-6	>C
	30. Name and address of person who completed cause of death (Item 23a) (
	RICHARD L. LINTHICUM, M.D.	7601 OSLER DRIVE	. TOWSON.	MARYLE	ND 21204
ate trar	31. Date filed (Month, Day, Year) 32 degistrar's Signature	Sacreti			
	THE TENDE OF THE PROPERTY OF T	The state of the s			

State

State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** JAÑŰÄRY BELLA RING 2006 10:00P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 6503 PARK HEIGHTS AVE. APT. 3-D BALTIMORE N/A | If Under 24 Hrs. | 8. Date of Birth | Hours | Min. | 10/16/1902 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Months Days Birthplace (State or Foreign Country)
 GERMANY **Funeral** 1□M 21 F 326-12-8391 103 Director Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits e 23a or 28a-f show 1√2 Yes 2 □ No Director MD N/A BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6503 PARK HEIGHTS AVE. APT 3-D 21215 U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, other then "naturel", or Items Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No WHITE ģ Specify 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **SEAMSTRESS** GARMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Is marked MEYER ROSENBUSCH SESSI REGENSTEIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 to Department of Health ar Important: If Itam 27 is eny Injury or other trau once. 8407 CHARLTON ROAD-RANDALLSTOWN, MD 21133 MARGARET STERN / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) CHEVRA AHAVAS CHESED 01/15/2006 RANDALLSTOWN, MD 21. Signa uneral Service L 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one was on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed Jepsus Due to (or as a consequence of) O. Box 68760, Completed by Physician/Medical munchia 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 Yes 2 □ No Director: After this certific d in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No Certification: To Be 26. Place of Death | Check only on Hospital: Other: 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 Mesidence 6 □Other (Specify) 3□ DOA 27. Man of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funarel Dire 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) -16090 16 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Old Cout Rd Batto 21208 57 3635 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

2006

Robert Shaw Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a,27,perME,9853,3/8/06 IT State of Maryland / Department of Health and Mental Hygiene 06-00247 NJM 1 - For Stata Registrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Robert Shaw 0926 January 10 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner NA Bon Secours Hospital Baltimore If Under 1 Year II Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 2–12–70 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 10XM 2□F 213-86-1645 35 Yrs. Director Md. Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at 1 Yes 2 □ No Director Md. NΔ Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ or iteme 23a Funeral 1823 Ruxton Avenue 21216 <u>USA</u> 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 end 2 should be filed within 72 hours after d Depertment of Health and Mental Hygiene. Important: If item 27 le marked other than "nature!", or item eny injury or other traumatic event, ILE Medical Experiment. Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th grade Maintenance Camden Yards-State 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Shaw, Sr. Betty ೭ Grays 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angel Stokeling Sister 1823 Ruxton Avenue, Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ₩ Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Mt. Carmel Cem. 1-18-06 Dundalk, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 lady Warne March F.H. East 1101 E. North Ave. -23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Concentric left ventricular hypertrophy of heart /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Examine use es the burial-transit Due to (or as a consequence of): nding physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) been signed by the e should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificete 1 OYes 2 🗆 No 2 No Yes Be 25. Was case referred to medical 26. Place of Death Check only one 1□ Yes 2□ No Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient ZXER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funerel Director; After this certific completely filled in by the funeral director, To the Hospitel o within 24 hours aft To the Funerel Di

State

7 HE WILL M. Kin. 31. Date filed (Month, Day, Year)

3 Suicide

29a Certifier

Medical

4 ☐ Homicide

29b. Signature and title of certifier

6 ☐ Could not be

-cas 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number OCME

111 Penn Street

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) January, 11, 2006

Baltimore, Maryland 21201

281. Location (Street and Number or Rural Route Number, City or Town, State)

Registrar

28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1:30 PM Lillian Belle Schaeffer January 13 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Upper Chesapeake Medical Campus Bel Air Harkord If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) March 8, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 80 219-18-7458 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. fnside City Limits 28a-1 show other traumatic ayant, the Medical Examiner must be notified at 1 ☐ Yes 2 🙀 No Maryland Harford Director Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 428 Haslett Road U.S.A. 21085 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White. Be Completed by 3 Nidowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene Important: if itsm 27 is marked other than "natural; any injury or other traumatic event, the Medical Example. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th Grade Colfege (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Thomas Eser Minerva Beecher-Frederick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Russell M. Schaeffer, Jr. (son) 428 Haslett Road, Joppa, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State | Donation | Specific | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Comment | Co 1/17/2006 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 24 hours /Medical Examiner 36 hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Be Completed by Physician/Medical Examiner

Hospitel or Attending Physicien: Division

Baltimore, Maryland 21215-0036

To the Hospitel or Attendin, within 24 hours after death.
To the Funerel Director: Att completely filled in by the fur

resulting in death) Last	Due to (or as a consec	quence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet: 4 □ Pregnant at time of o 9 □ Unknown	af death 3 Ectopic pr			23d. Date of delivery Month Day Year
Part II. Other significant conditions co	ntributing to death but not re-	sulting in the underlying o	ause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
				24a. Was an autopsy performed 1 Yes 2 8 1	
25. Was case referred to medical			26. Place of De	ath (Check only one)	
examiner? 1 ☐ Yes 2 ◯ No	Hospital: 1 Inpatient 2	ER/Outpatient 3 DO	Othor	Home 5 Residence	6 ☐Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of fnjury - At h building, etc. (Speci	nome, farm, street, factor	y, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
29a. Certifier Certifying Phy (Check only one) 2 Medical Exam	vsician: To the best of my kn iner: On the basis of examin and manner stated.	owledge, death occurred ation and/or investigation	at the time, date and place, in my opinion, death occ	e, and due to the cause urred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
29b. Signature and title of certifier		290	c. License number	29d. [Date signed (Month, Day, Year)

D0053568 Hanua 13

500 Upper Chesapeake Dr., Bel Air, MD

Registrar DHMH 17 Rev 1/2001

State

o completed cause of death (Item 23a) (Type, Print)

(cal 32. Registrar's Signatur

THOMPSON MD

2006

Upper Chesapeake

			1 - For State Registrar	State of N	Maryland / De	partment of I ertificate of			giene	6	00794
I	Physici /Media	al	1. Decedent's Name (First, Middle CARMELLA		SE1			2. Date of De Month 01	13 2	Year 2006	3. Time of Death 6:00 A M
	Examir Funeral	er	4a. Facility Name (If not institution FOREST HILL H 5. Social Security Number	EALTH & REHA		FOREST	If Under 24 H	rs. 8. Date of Bin	4c. Count	ORD 9. Births	place (State or Foreign
	Director		212-22-8652 Usual Residence of Decedent 10a. State 10b. County	1 □ M 2 🙀 F	88 Yrs.	Months Days	Hours Mi	Month, Da 4-13-		Balt	imore, MD
	the Maryla r 28a-f shov	rector		rford	Stree				10g. Citizen of		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
99	be filed within 72 hours after death with the Maryland tel Hyglene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examinar must be recitived at	/ Funeral Director	1160 Taylor 11. Marital Status 1 Never Married 2 Mar	12. Was Deceder Armed Forces 1 Yes 2 5	?	211. 3. Was Decedent of If Yes, specify Cub. 1 Yes 22 No	Hispanic Origin? an, Mexican, Pue	(Specify Yes or No erto Rican, etc.)	Bla	ck, White,	
Baltimore, Maryland 21215-0036	within 72 hours ane. than "natural", te Medical Exe	Completed by	3 Widowed 4 □ Divorced 15. Deceder (Specify only higher Elementary/Secondary (0-12)	Year or Dates It's Education st grade completed) College (1-40)	16a. Dec (Gi life	cedent's Usual Occup ve kind of work done DO NOT use retire	oation during most of w	vorking	16b. Kind of B	lusiness/In	
/land 2	be filed itel Hygi od other event, ti	To Be Co	8th 17. Father's Name (First, Middle, John Detota	Last)	Be	amscress	18. Mother's N	_{ame (First, Middle,} a Guari	Maiden Sumar	Tayl	ors.
, Mar	d 2 th a 7 Is		19a. Informant's Name/Relations Conrad & Cat			iling Address <i>(Street</i>					Code)
imore	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other onca.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		20b. Place of Dis cemetery, ci	position (Name of rematory or other pla edeemer	сө)	Date 16/2006	20c. Location	- City or To	
Ball	permit Depart Import any in		21. Signature of Funeral Service	M. Zenne	uo	22. Name and Addre	onklin	Joseph I	Baltim		MD 21224
	Physician /Medical Examiner		23a. Part1. Enter the diseasé, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	a. In	s a consequence of)	e Reno	ng, such as cardi	SEAS		/	Approximate Interval Between Onset and Death HEAV.C
8760,	icate be executed physicien and s the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С	s a consequence of): s a consequence of):						
.O. Box 68	deeth certif e attending id for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3	ECtopic pregnanc	/			ite of delive	ery Day Year
rds, P.	w requires that the been signed by th should be detache	ρ	Part II. Other significant conditi	ons contributing to death	but not resulting in the	underlying cause giv	ren in Part I.	23e. Did to		tribute to th	ne cause of death?
al Records,	The law ate has b page 2 sl	Completed						24a. Was autop perfor 1 \(\text{Yes}	rmed?	prior to cor death?	psy findings available impletion of cause of
ion of Vital	Attending Physicien: Thr death. r death. sctor: Atter this certificate by the funeral director, pag	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Man of Death 1 1 Natural 5 Pendir 2 Accident investi	Hospital: 1 Inpat	jury 28b. Time	of 28c. Injui	er: 4 Nursing	Home 5 Resident Residence	dence 6 🗆 Oth		v)
Division	Dir	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	sined 286. Place of II	njury - At home, farm, setc. (Specify)	street, factory, office		28f. Location (S City or Tow		er or Rura	Il Route Number,
(0	To the Hospital within 24 hours a To the Funeral I completely filled	Medicai	one)	ng Physicien: To the bes Exeminer: On the basis and manner s	of examination and/or	investigation, in my o	pinion, death occ	ce, and due to the courred at the time, o	cause(s) and ma date and place,	anner as st and due to	ated. the cause(s)
Ψ	To To con	-	29b. Signature and title of certifie	mel MMC	2 mp	29c. Licens	9 1958	3	29d. Date signe Tahnar		3, 2006
			DR. MANUEL LA	ZATIN, 8 ZA	W STREET,		MD 210	01	/		
	Sta Registr		31. Date filed (Month, Day, Year) JAN 1 7	2006 37 Regis	trar's Signature						

State of Maryland / Department of Health and Mental Hygien 206

00795

					Ce	rtificate	of L	Death		F	leg. No.		
		1. Decedent's Name (First, Middle, I	ast)	-						2. Dete of Dee			3. Time of Death
Phys	ician dical	Osie			S	haffer				Month January	Dey 5. 200	Year 06	7:30 PM
	niner	4a Fecility Neme (If not institution, g	ive street end nu	mber)			41	b. City, To	wn, or Lo	ocation of Deeth	4c. County		7.30 111
		Pineview Future	Care					Clint	on		Princ	ce Ge	orge's
Funer	al	5. Social Security Number 6.	Sex	7. Age (In yrs. i	last birthday)	If Under 1 Y	'ear	If Under	24 Hrs.	8. Date of Birth	1		place (State or Foreign
Directo		430-03-0887	1 ∑]M 2□F	98	Yrs.	Months D	eys	Hours	Min.	Oct. 15			sissippi
ט		Usuel Residence of Decedent	1						L	10001 13	, 1507	1110	отоотры
ylen Fow		10a. State 10b. County		10c. City	y, Town or Lo	cation						1	10d. Inside City Limits
Me -	호	Maryland Prince	George's	s Up	per Ma	arlboro)						1 □ Yes 2 No
h th	Director	10e. Street end Number		1		10f. Zip Co	de			1	0g. Citizen of	Whet Cou	ntry?
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deat	Funerai	11. Marital Status	12. Was Dece	edent Ever in U,	S. 13.	Was Decedent	of His	spenic Ori	gin? (Sp	ecify Yes or No- Rican, etc.)			an Indian,
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Ours our	by	3 X Widowed 4 ☐ Divorced	If Yes, Giv Year or D	re ates: 1945		1□ Yes 2] <u>X</u>)	No	Specify:			Specify	" Bla	ck
5-0 72 hg	Completed	15. Decedent's I	Education		16a. Dece	lent's Usual O	ccupe	tion			16b. Kind of B	usiness/In	dustry
within one than r	pje	(Specify only highest g Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	kind of work d DO NOT use re	one al etired)	uring mos	t of work	ing			
d 212 filed within Hygiene. ther than int, the w	Š	12	oomogo (10.017	Unio	n Accou	nta	ant			Lumber	Indu	stry
- 0-05	Be	17. Father's Neme (First, Middle, Las	st)		-			18. Mothe	r's Name	e (First, Middle, I		_	
should be of Mental marked o	.0	Jeff Shaffer						E.1 m	ira	Johnson			
Maryla 12 should h end Men 7 is marke		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	g Address (St	reet a			el Route Number	. City or Town.	Stete. Zio	Code)
		Verna Shaffer-K	olen (Da	ughter)	9714	Natali	e I)r.,	Uppe	r Marlb	oro. MD	207	72
s 1 en f Heel ftem 2	1	20a. Method of Disposition	•	20b. PI	ace of Dispo	sition (Name o	of				20c. Location -		
Baltimore, bemit. Pagas 1 er Depertmant of Hee mportant: if Item; any injury or other		1 Burial 2 □ Cremation 3		State		natory or other)	1			•	
Itir itima internal		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		Jac		Cemeter	-	-4 F 124		/14/06	Lexa,	AR	
Balti permit. I Depertin Importar any inju	SUC SUC	21. Signature of Futieral Service Lick	2	1		. Name end Ad Stepher	odress 1S	Funer	al E	lome			
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ש מ	Examiner												
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OX 68760, certificate be executed nding physicien end use es the burial-transit	2	resulting in death) Last			,							1	
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I KECOTGS, P.O. BK The law requiras thet the daath ata has been signed by the atter page 2 should be datached for r	Physicia	Part II. Other significant conditions	contributing to de	ath but not resu	Iting in the ur	derlying cause	a divoc	in Port I		23h Didto	haaaa	44444	the cause of death?
P.O. net the dand by the datached	hys		V= = 71	0	2101	Toollying Cause	givei	rair cutti.					
thet	by P	CANCER C	714	2	1103	YAOC	-			1010	s 2 No	3 Proc	ably 4 Unknown
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eata	ပိ									1 Ye	s ziANo	1 🗆	Yes 2 No
OT VITA Physician: rthis certific ral director,	Be	25. Was case referred to medical examiner?							of Death	(Check only one	9)		
hysic his o	ို	1 ☐ Yes 2)() No			R/Outpatien	3□ DOA	Other	4 Nur	sing Hor	ne 5□ Reside	nce 6 □Othe	or (Specify)
UNVISION OT VITAI RECORDS, to a Attending Physician: The law requires thater death. Director: After this certificata has been signe of in by the funeral director, page 2 should be of in by the funeral director, page 2 should be	Ë	27. Menner of Death 1 Natural 5 □ Pending	28a. Date o (Month	f Injury n, Dey Year)	28b. Time of Injury	28c. I	njury a	at	2	28d. Describe ho	w injury occurr	ed	
VISION Attending or death. ector: After by the fune	atio	2 ☐ Accident investigetion	on .					es 2□N	ło				
VIS Pr de by ti	불	3 Suicide 6 Could not to determined	289. Place	of Injury - At hor g, etc. (Specify)	ne, farm, stre	et, factory, offi	ce		2	8f. Location (Str City or Town	eet and Number	er or Rura	Route Number,
s affe di Dir	Certification:	- Table 1978-100	buildin	g, oto. (<i>Specify</i>)						Oily of Town	, State)		
DIVISION Of VITAI RECORDS, P.O. By To the Hospital or Attending Physician: The law requiras thet the daath within 24 hours after death. To the Funeral Director: After this certificata has been signed by the atta complately filled in by the funeral director, page 2 should be datached for	ia (29a. Certifier 1 Certifying P	hysician: To the I	est of my know	ledge, death	occurred at the	e time	, date and	place, a	nd due to the ca	use(s) and ma	nner as sta	ated.
n 24 n 24 ne Fu	edicai	(Check only 2 Medical Exa	miner: On the ba and mann	sis of examination	on and/or inv	estigation, in m	ny opir	nion, death	h occurre	ed at the time, da	ite and place, a	ind due to	the cause(s)
To the	ž	29b. Signature and title of certifier				29c. Lic	ense r	number		29	d. Date signed	(Month, E	Day, Year)
		1/10 -				D	18	CU		T	ALK) AC	14 1	2006
	1	30. Name and efficess of person who	completed cause	of death /Itom	23e) (Tvna 5	Print) >	U.	١- د		7,	" OCTAL	7	0, 200
		Pellycordice	III A _ A	17070	CX A	LINE	0	W.	=P	LUAI DE	AF IA	1	20602
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	Physicia /Medic	an	1. Decedent's Name (First, Middle LAKS HIM		HNI						Date of Dea Month	th Day	2 O		3. Time of Death	м
	Examin	er	4a. Facility Name (If not institution HOWARD COUN	ITY GENE	RALH			OL	UM	Death B1A			ounty of De			
	Funeral Director		5. Social Security Number NA Usual Residence of Decedent	6. Sex 7 1 □ M 2 💢 F	. Age (In yrs. I	Yrs.	If Under 1 Y Months Da		Under 2 Hours	Min.	Date of Birth (Month, Day une 15	, Year)	9. B 15 Pa	Country		gn
	Maryland -f show lied at	tor	10a. State 10b. County	gomery	10c. City	y, Town or Lo	omac							10d	. Inside City Limit	
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Maryland 21215-0036	in 72	Completed	15. Deceder (Specify only highe Elementary/Secondary (0-12)	it's Education st grade completed) College (1-	4or 5+)	(Give	dent's Usual O kind of work d DO NOT use re	one durii	n ing most	of working		16b. Kind	d of Busines			
121	e filed with It Hygiene, other than		UNK	(1004)		<u></u>	House			4- 81 /5			own h	ome		
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lary	2 should and Men is marke aumatic		19a. Informant's Name/Relations	ship (Type, Print)		19b. Maili	ng Address (St	reet and	Number	or Rural A		r, City or 1	Town, State	Zip C	ode)	
Baltimore, N	Pages 1 and 2 should hent of Health and Mer int: If Item 27 is marke iry or other traumatic		Rohit Saini/gr 20a. Method of Disposition 1 □ Burial 2 【**XCremation	3 □Removal from S	1 0	lace of Dispo	8 Signa esition (Name of matory or other	of	1	Date anuar	y 15,	20c. Loca	ation - City o	or Town	n, State	
Baltin	permit. Pag Department Important: t any injury o once.		21. Signature of Funeral Service	Licensee	West	22	del Cre 2. Name and A onaldso 411 Ann	ddress o	of Facility	2005 al Hor Road			ton, l		١.	
			23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final	r complications that ca only one cause on ea	used the death ch line.								. III . Z I .	A Ir	pproximate iterval Between inset and Death	
8760,	/Medical Examiner bhysician and sthe burial-transit	ai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury that initiated events resulting in death) Last	b	or as a consequence as	uence of):	fact	un							weter)
.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 ☐ Feta int at time of d	death 3	Ectopic pregn					23	d. Date of d	lelivery Da	ay Year	200
<u>α</u>	uires that signed b id be deta		Part II. Other significant conditi	ons contributing to dea	ath but not res	ulting in the u	nderlying caus	e given in	in Part I.		23e. Did to	-		to the Probab	cause of death?	νn
Vital Records,		Completed by	anemia,	unna	y K	2ct	infec	tra	2		24a. Was a autops perfor	sy	24b. Were prior to death?	comp	y findings availab letion of cause o	ale f
Vita	Physician: The this certificate har al director, page	Be	25. Was case referred to medica examiner?	Hospital:	·			Other			Check only or					
o	iding Physith. Ith. : After this funeral dii	tion: To	1 Yes 2 No 27. Manner of Death Natural 5 Pendi 2 Accident invest	28a. Date o		28b. Time o Injury		Injury at Work?		280	5 Resid			ecify)		
Division	al or Atter s after dea al Director ed in by the	Certification:	3 Suicide 6 Could 4 Homicide determ	nined 286. Place	of Injury - At ho g, etc. (Specif	ome, farm, str	reet, factory, of	fice		28f	. Location (S City or Tow	itreet and n, State)	Number or	Rural F	loute Number,	
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (29a. Certifier 1 Certifyi (Check only one)	ng Physician: To the I Examiner: On the ba and mann	sis of examina	wledge, deat tion and/or in	h occurred at the vestigation, in	ne time, my opini	date and ion, deati	l place, and h occurred	I due to the c at the time, c	cause(s) a date and p	nd manner place, and d	as state	ed. e cause(s)	
	with To t	Σ	29b. Signature and title of certific	MD, FCC	P		29c. Li	cense nu	umber				signed (Mo			
,	\cap					222\77:	Drint) 14	368	145	11/	1011	Jan	n. 14		2006 P	
_	J		7350 Ovz	ce Priv	or death (Item	Cun	Som MI	M	0	210	46	0,10	U,T	<u> </u>	7	
	Sta Registi	5	31. Date filed (Month, Day, Year	7 2006	gistrar's Signa	ture	Service of the servic									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Shipp Roberta Margaret 608 FM 2006 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bayview Medical Center Baltimore Baltimore City Johns Hopkins If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2√2F 81 215-22-1428 Yrs Baltimore, Maryland Director March 9, 1924 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland anent of Heath and Mental Hygiene.
ansi: Hitem 27 Is marked other then "natural", or items 23a or 28a-1 show ury or other treumatic event, the Medical Experiment he notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No Be Completed by Funeral Director MD Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 1962 Wareham Road **USA** 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White 3 ☐Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 years Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Catherine Mc Leod ပ္ John W. Durner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1961 Wareham Road, Dundalk, MD. 21222 William F. Parks son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State January 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If eny injury or once. Cardens of Faith Cemetery Rosedale, MD. 17, 2006 22. Name and Address of Facility.
Connelly Funeral Home Of
7110 Sollers Point Road, 21. Signature of Fun Service Licensee Dundalk, P. A. Dundalk, Md. 23a. Part1/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Seps15 disease or condition resulting in death) t. COII weeks /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, 1 and leading to mine flat cause. Enter Underlying Cause (Disease or injury Qualto (or as a consequence of) Examine use as the burial-transit o the Hospitel or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy ō Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🖾 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? certificate 1 ☐ Yes 2 No 1 Yes 2 🔀 No Be 25. Was case referred to medical examiner? 26. Place of Death Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Medical Certification; 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. investigation М 1 ☐Yes 2 ☐ No within 24 hours after death To the Funerel Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES- 000 January 12, 2006 30. Name and address of Terson who completed cause of death (Item 23a) (Type, Print) JEFFREY HIGHFILL, MD 21224 Baltimores MD

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32 Registrar's Signature

			1 - For State Registrar	State of Maryland / Depa Cea	rtificate of E			ene U C	00190
I	Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month		3. Time of Death
	/Medic		Ruth M. Sebring		T		Jan.	15 200	06 3:00 P ^M
	Examin	er	4a. Facility Name (If not institution, give str	eet and number)	4b. City, Town, or	Location of Death		4c. County of	Death
			75 Bill Leight Rd. 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Conc If Under 1 Year	wingo If Under 24 Hrs.	8. Date of Birth		ecil
	Funeral Director			1 2 F 85 Yrs.	Months Days	Hours Min.	Month, Day,	Year) 1920	9. Birthplace (State or Foreign Country) PA
	D		Usual Residence of Decedent				mar orr	1520	
	anylau show	_	10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	he M	ecto	MD Cecil 10e. Street and Number	Conowii					1 Yes 2 No
	with Sa or	٥	75 Bill Leight Rd.		10f. Zip Code	918		og. Citizen of Wr USA	nat Country?
	ms 23	Funeral Director		. Was Decedent Ever in U.S. 13.	Was Decedent of His If Yes, specify Cubar		ecify Yes or No-		- American Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural; or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinat retriest be rigitlized at once.	by Fur	1 Never Married 2 Married 3 XVidowed 4 Divorced	1 ☐ Yes 2 📉 No	If Yes, specify Cubar 1 ☐ Yes 2 No	Specify:	Rican, etc.)	Specify:	White, etc. White
Š	72 hor	Completed	15. Decedent's Educa (Specify only highest grade of	tion 16a. Dece	dent's Usual Occupa	tion	1	6b. Kind of Bus	iness/Industry
2	ithin 7 ne. Ne.	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	kind of work done di DO NOT use retired)	uring most of work	ing		
2	fled w flygier her th	Co	17 Fethodo Namo (First Middle 1 and)	n/a Hor	nemaker	40 Mark - 1- No.	(F)	Own I	
Maryland 21215-0036	uld be fi Mental H trked of tilc ever	To Be	17. Father's Name (First, Middle, Last) William O. Greenwo	ood			e <i>(First, Middl</i> e, <i>M</i> ed F. Bu)
Mar	nd 2 sho Ith and I 27 is me r traume		19a. Informant's Name/Relationship (Type Scott N. Sebring/S		ng Address (Street a				
re,	of Hea		20a. Method of Disposition	20b. Place of Dispo	osition (Name of matory or other place				ity or Town, State
E	Page nent c ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Rer `4 ☐ Donation 5 ☐ Other (Specify)	Metro Cr		1/17/0	06	Catonsv	ille, MD
Baltimore,	permit. Departr Imports any inju		21. Signature of Funeral Service Licensee Aichte 23a. Part. Enter the disease, or complice shock or heart failure. List only one	Elaglo Le	2. Name and Address emmon Ful	s of Facility neral Hor	me of Du	ılaney \	/alley, Inc.
	8		23a. Part . Enter the disease, or complica shock, or heart failure. List only one	tions that caused the death. Do not en	U. W. Pado ter the mode of dying	nia Rd., such as cardiac	or respiratory arre	um, MD st.	21093 Approximate
	Physician :		Immediate Cause (Final disease or condition	Acute Respirato					Interval Between Onset and Beath
	/Medical		resulting in death)	Due to (or as a consequence of):					1
	Examiner		Sequentially list conditions. b.	Metastatic live	er cancer				weeks
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that injuried executed.)	Oue to (or as a consequence or): Probable Prima:	rv Colon c	ancer			weeks
8	rtificate be executed ng physician and i as the burial-transit	xan	that initiated events c. resulting in death) Last	Due to (or as a consequence of):					
68760,	sician burit	aiE	d						
687	ificate g phy: as the	Medical	a. ,						
Вох		M/u	230. Was decedent pregnant	. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 3□	☐Ectopic pregnancy			23d. Date	of delivery
	ed for	sicia	in the past 12 months? 1 ☐ Yes 2 No		Other (specify)			Mont	h Day Year
0	es that the death cer igned by the attendir be detached for use	Physician/	9 Unknown						
	res th	by	Part II. Other significant conditions contr	buting to death but not resulting in the u	inderlying cause give	n in Part I.			oute to the cause of death? Probably 4 Munknown
Ö	w require been si should I	Completed							
Records,	has l	mpl					24a. Was an autopsy	/ pri	ere autopsy findings available or to completion of cause of ath?
	icien: The certificate rector, pag	e Co	25. Was case referred to medical				perform 1 □ Yes 2		Yes 2□No
Vita	Physicien: The this certificate had al director, page	0 8	examiner?	spital: 1 Inpatient 2 ER/Outpatier	nt 3 DOA Othe		h <i>(Check only one</i> me 5 X Reside		(Pagaika)
ot	Attending Physicien: The law requires that the death ce r death. c death. ector: After this certificate has been signed by the attendi	-	27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Time of Injury		at	28d. Describe ho		
jo	anding fath. or: After he funer	atlo	1 Natural 5 Pending 2 Accident investigation	(World, Day 16al) Injuly		es 2□No			
Division	al or Attences after death Pirector: d in by the	ertification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office		28f. Location (Str. City or Town,		or Rural Route Number,
	To the Hospital or Attentwithin 24 hours after deatl To the Funerel Director: completely filled in by the	edical C	29a. Certifier 1 Certifying Physic (Check only one) 1 Medical Examine	ian: To the best of my knowledge, deat r: On the basis of examination and/or in and manner stated.	h occurred at the time	e, date and place, inion, death occurr	and due to the ca red at the time, da	use(s) and mani te and place, an	ner as stated. Indicate the discrete di
	ro the vithin ro the comple	Me	29b. Signature and title of certifier	O COLOR	29c. License	number	29	d. Date signed	(Month, Day, Year)
	->-0		101/15	San WO	718	3779	9		16,2006
	2		30. Name and address of person who com		Print)		0	10	
	0 `		Albert S.C. Sun,		ord Rd., S	Suite 105	; Fallst	on, MD	21047
			31 Date filed (Month, Day, Year)	32 Registrar's Signature					

Registrar

DHMH 17 Rev 1/2001



Physician

/Medical

Examiner

Director

Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or iteme 23a or 28a-f ehoventhing or other traumatic event, the Madical Examiner must be notified at once.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 27. Manner of Death Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mugele arth RESODD JANUARY 12 2006

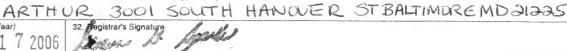
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State Registrar

31. Date filed (Month, Day, Year) 2006

ANGELE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month Year January 13,2006 Timothy James Smith 4:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 107 Erie Court North East Cecil If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 11X M 2□ F Vrs Director March 23,1954 Maryland 220-62-0547 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show The Medical Examiner must be notified at Maryland Cecil North East 1 ☐ Yes 2 ☑ No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 107 Erie Court 21901 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "naturel", or iteme 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after MYYes 2□No IfYes, Give Vietnam Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 20XNo Specify: ģ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wir Department of Health and Mental Hyglent importants if item 27 ie marked other that eny injury or other traumatic event, Inst. 2008. Years Sales Mananger Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary H. Dosch James Arthur Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 513 Riverside Road Essex, Maryland Mrs. Mary H. Smith (Mother) 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Sacred Ht. of Jesus Cem. 1/16/2005 Dundalk, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Exter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Intect or Quell mydreid /Medical Due to (or as a consequence of) Examiner Blase Connel Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the burial-transit COP D and Due to (or as a consequence of): Records, P.O. Box 68760, attending physician Physician/Medical as IF FEMALE esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan autopsy performed? Yes 22(No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 5 Residence 6 ☐ Other (Specify) 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of To the Hospital or Attending Pl within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral 27. Manner of Death 28d. Describe how injury occurred Certification: After Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 13 06 I've cel Is MP D04823 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHIH HSW. 223 men 111 Wes 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 7 2006 Registrar

			For State Registrar	State of Maryland /			nt of He te of E			giene Reg. No.		10801	
\$ -	Physici	D-	Decedent's Name (First, Middle, Last) Anto	inette Theres	a	Scl	riefe	er	2. Date of Dea	Day	Year 0, 2006	3. Time of Death 5:30 A	vI
	/Medic Examin		4a. Facility Name (If not institution, give s 8257 Delhaven Ro			4b. City		Location of Death		Safe	County of Death		
1.02	Funeral Director		5. Social Security Number 6. Sex 214-26-1874	7. Age (In yrs. last	birthday) Yrs.	If Unde Months	r 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	y, Year)	9. Birth Cou	place (State or Foreig intry)	n
he Maryland	28a-f show	Director	Usual Residence of Decedent	10c. City, To		ndall					izen of What Co	10d. Inside City Limits 1 Yes 2 No	
th with t	23a or 2	al Dir		Road		101. 2	p Code	21222			nited St	4	
:1215-0036 within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Importent: or Items 23a or 28a-f show Importent: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ite Medical Examinar must be notified at ODEs.	by Funeral	11. Marital Status 1 □ Nøver Married 2 □ Married \$\text{2}\text{Widowed 4 □ Divorced}	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Dece f Yes, spe 1 ☐ Yes	cify Cuban	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		14. Race - Amer Black, White Specify:		
21215-0036 ad within 72 hours af	giene. er than "natu , it e Medical	Completed	15. Decedent's Edu- (Specify only highest grade Elementary/Secondary (0-12) 8 Years		(Give life. i	kind of w DO NOT	ial Occupations done du use retired)	uring most of wor	rking	Ba	ind of Business/l ltimore blic Sch	County	
Maryland 2:	Mental Hy larked othe latic event	To Be (17. Father's Name (First, Middle, Last) Michael Robusto					Jenny	ne (First, Middle, Nardone	9			
, Mar and 2 sh	ealth and n 27 is m ter traum		19a. Informant's Name/Relationship (Ty, Mr. Joseph Schrie	fer (Son)	306	A. 1	Jpper.	nd Number or Ru landing	and the same of th	ssex	, Maryla	and 21221	
altimore,	ment of H lant: if Itel lury or oth		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	lemoval from State	etery, crer	natory or	me of other place etery) 1/13/	2006		ocation - City or 1 ltimore,	own, State Maryland	
Balt permit.	Depart Import eny in		21. Signatur Funeral Service Licens	- Kul	D	uda -1 7922	Ruck I Wise	Ave. D	Home of undalk,	Mary	dalk, Ir yland 2	nc. 1222	
1	nysician Medical xaminer		23a. Part1. Enter the fisease, or complishock, or hear failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. Decause on each line. A cuts my Due to (or as a consequence)	100,4		i			rest,	*	Approximate Interval Between Onset and Death (man 1/h S	
>	\$ -	Examiner	Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence	ce of):						1		
8760, cate be executed	physicien and the burial-transit	dical	resulting in death) Last	Due to (or as a consequence	ce of):								
Records, P.O. Box 6 The law requires that the death certifi	ed by the attending detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3 ☐	Ectopic (pecify)				23d. Date of delin Month	very Day Year	
rds, P quires that	ed E	by	Part II. Other significant conditions cor	ntributing to death but not resultin	g in the u	nderlying	cause give	n in Part I.	23e. Did to		use contribute to	the cause of death?	n
	ate hes	Completed							24a. Was autop perfo 1 🗆 Yes		prior to o death?	opsy findings available ompletion of cause of	в
of Vita Physician:	nis certificate director, pag	Be	25. Was case referred to medical examiner?	lospital:			Othe	-	ath (Check only o				_
n of	ifter this	on: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	1 Inpatient 2 ER/	Outpatier b. Time of Injury		28c. Injury Work	at ?	28d. Describe h			ıfy)	
Division of	within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Plage of Injury - At home, building, etc. (Specify)	, farm, str	M eet, facto	- 12	es 2 □ No	28f. Location (5 City or Tow			al Route Number.	
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To th	To 11	×	29b. Signature and title of certifier)		25	c. License				te signed (Month		
)			pudith & K	ary MD	.) (**	Deital	117	912		h	10,20	006	
5	1		30. Name and address of person who con Sidney Kimmel	Ch CV @ Vehns	a) (Type,	Kirs	Ba	Ethmore	e,MD :	212	31-1000		
	Sta Regist		31. Date filed (Math, Day Year)	32. Regultrar's Signature	K	Car	12						

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2 37AM Month Day **Physician** Patricia Anne 2006 Schultz burary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center
5. Social Security Number 6. Sex 7. Age Westminster
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Carroll Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1 □ M 2**X**□ F Months Director 220-38-8294 64 Aug 31. 1941 MD Usual Residence of Decedent show 10a, State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "netural", or Items 23s or 28e-f shov r other treumetic event. Ine Medical Examinar must be notified at 1 ☐ Yes �☐ No Director MD Carroll Westminster 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 203 Drumcastle Court 21157 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ☐Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene, other then Elementary/Secondary (0-12) College (1-4or 5+) Realtor/Administrator Realty/Finance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ages 1 and 2 should be fill not of Health and Mental H t: If item 27 is marked ot Be Joseph E. Pilkerton Mary R. Constantino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Richard Schultz (Spouse) 203 Drumcastle Ct., Westminster, MD 21157
20b. Place of Disposition (Name of Disposition (Name of Disposition) City or Town, State 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition permit, Pages 1 Department of H Importent: If ite any injury or oth 1/16/06 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State All County Cremation * 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
HAIGHT FUNERAL HOME & CHAPEL (Box 195) 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately 100 Approximately Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) INFARCTION Priysician ACUTE /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ARTERIAL PERIPHERAL 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed RENAL ARTERY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed CEREBROVASCULAR 1 Tyes Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 20 No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. М 1 □ Yes 2 □ No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the D0017695 who completed cause of death (Item 23a) (Type, Print) ABDALLAH HELOU, M, U. CARROLL HOSPITAL CENTER 32. Pegistrar's Signature State Registrar

DHMH 17 Rev 1/2001

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death

Baltimore, Maryland 21215-0036

or Attanding Physician: The jaw requires that the deeth certificate be executed

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certificate

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Box 68760.

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of Vital Records,

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend unpend item # 1 23a 27 penML, 654, 4/36 II Copies Are Legible. State of Maryland Department of Health and Mental Hygiens 0.06

1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Karen Salmanson JANUARY 11, Ann 2006 1849 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NORTHWEST HOSPITAL CENTER RANDALLSTOWN BALTIMORE 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 XF Yrs 199-44-5726 Director 40 Jan 28,1965 PA Usual Residence of Decedent or 28a-f ahow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Eldersburg 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6671 Mid Summer Night Ct. Completed by Funeral 21784 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 end 2 should be filed within 72 hours after onent of Heelth and Mental Hygiene.
ant: if Itam 27 ia marked other than "natural", or ital
ary or other traumatic avent, the Medical Examinal Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐XNo Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) USA Teacher/Homemaker 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Frederick N. Schwenk Betty C. Reitnauer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Salmanson Mr. Josh H. 6671 Mid Summer Night Ct., Eldersburg, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State permit. Page Department of Important: if any injury or ′13/06 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation Sykesville, MD 21. Signature of Funeral Service Licensee HAIGHT FUNERAL HOME & CHAPEL (Box 195) Han 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Beh Interv Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a. Acute coronary artery thrombosis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): for use as the burial-transit Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month 4 Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown cate has been signed page 2 should be del Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 DUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 ☐ No 24a. Was an 1 Yes 2 No 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) X Yes 2 No 2X ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Injury within 24 hours efter death.

To the Funeral Director: All completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) OCME JANUARY 13, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Southall, mp tomeki

Registrar DHMH 17 Rev 1/2001

State

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JAN 1 7 2006

31. Date filed (Month, Day, Year)

ind

32 Registrar's Signature

111 PENN STREET, BALTIMORE, MARYLAND, 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Lawrence J. Sheeler 04:57AM 2006 12 January /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death AGNES Baltimore Health Care If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 213-05-3116 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 88 1X M 2□ F Yrs. Director Oct.28, 1917 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "neturel", or itema 23a or 28a-f showing Medical Examiner must be notified at MD 1 XYes 2 No Director Baltimore 10e. Street and Number 3138 Strickland Street 10g. Citizen of What Country? 10f. Zip Code 21229 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1X Yes 2 No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White <u>გ</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) t and 2 should be filed w Health and Mental Hygier tem 27 is marked other th Sample Maker PPG Industries 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Lawrence Sheeler Frieda Gilbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health as Important: if item 27 is any injury or other treas-3138 Strickland Street; Baltimore, Maryland 21229 Mary E. Sheeler Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State New Cathedral Cemetery 4 Donation 5 Other (Specify) 1-14-06 Baltimore, Maryland 22. Name and Address of Facility Sterling—Ashton—Schwab—Witzke Funeral Home of CatonsvIlle, Inc. 21. Signature of Funeral Service Licensee 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

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Approximate

Approximate Immediate Cause (Final disease or condition resulting in death) **Physician** Comunity Aquired 2 weeks Pheumonia /Medical Due to (or as a consequence of) Examiner Shoc Septic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of) Examine Due to (or as a consequence of): Physician/Medical Box IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 2 No 1 🗆 Yes 1 ☐ Yes 2 ☐ No Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🗙 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nnpatient 2 ER/Outpatient 3 DOA of To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier Medical 9509 Loctor January, 12, 2006 1041 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Baltimore, MD, 21229 2 degirmence Caten 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

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4	Funeral		5. Social Security Number 6. Sex 7. A	ge (In yrs. I	ast birthday	/) If Under Months	1 Year Days	If Under 24 H Hours M		lirth Day, Year	r)	9. Birthpl	ace (State or Foreign try)
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36	s afte	by Fi	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ If Yes, Give Yes, Give Yes, Great or Dates:	No TILITY		1□ Yes 2		Specify:	,,			Whi	
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멀	oe file al Hy d oth	Be (17. Father's Name (First, Middle, Last)					18. Mother's N	ame (First, Middl	e, Maide	n Sumam	e)	
Maryland 21215-0036	Ment Ment arke	ပ္	Alexander Sokas						ozaliia				
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Heatih and Mental Hygiene. Important: If item 27 is marked other than "natural", or itama 23a or 28a-f show any injury or other traumatic event, the Madical Examinar must be notified at once.		1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	l ce	metery, cre	ematory or oth n Nati	her blace						
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5	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	dical	29a. Certifier (Chack only one) 1 Certifying Physicien: To the bess 2 Medical Examiner: On the basis	or examinati	vledge, dea ion andvor in	th occurred a	t the time	e, date and pla	ce, and due to the	cause(s	s) and mar	ner as sta	ted.
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	or 28	Director	10e. Street and Number	_		10f. Zip Code			10g. Citizen of	What Cou	•
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			23a. Part1. Enter the disease or comp shock, or heart failurer List only o	ications that caused the de ne cause on each line.	ath. Do not ent	er the mode of dyin	g, such as cardia	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
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P.	that the de led by the a detached f	Phy	9 ☐ Unknown Part II. Other significant conditions co	ntributing to death but not re	esulting in the u	nderlying cause give	en in Part I	23e. Did to	obacco use con	Inhute to t	he cause of death?
ds,	Se 200	d by					on any contract of			3 🗆 Prot	
of Vital Record		Completed						24a. Was	an 24b.	Were auto	ppsy findings available
H.	The ate h page	Com						autop perfo	rmed?	death?	mpletion of cause of 2□ No
/ita	Phyaician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		04		eath (Check only o	ne)_		
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ion	Attending ir death. ector: After by the fune	atior	1 ☐ Matural 5 ☐ Pending investigation	28a. Date of Injury (Month, Day Year)	Injury	Work	<br Yes 2 □ No		,,		
Division	E Site	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str cify)	eet, factory, office		28f. Location (S City or Tox		per or Rura	al Route Number,
_	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	edical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Example one)	sician: To the best of my k ner: On the basis of exami	nowledge, deatl	n occurred at the time vestigation, in my op	ne, date and place	ce, and due to the curred at the time,	cause(s) and ma	anner as s and due to	tated. o the cause(s)
	othe omple	Med	29b. Signature and title of certifier	and manner stated.		29c. License			29d. Date signe		
)	->-0			M	· D ·	125.	7722	-	JANUARY	< 14	4 2006
	10		30. Name and address of person who co			Print) Non	TH WEST				
			31. Date filed (Month, Day, Year)	32. Registrar's Sig		RT ROAP,	2ANDALL.	STOWN N	10 211	33	
•	Sta Registr			32. Hegistrar's Sig							

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner lohns Hopkins Bayview Medical Cordor Baltimore 5. Social Security Number If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) 1/6/1913 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Davs Min 1⊠M 2□F Hours 93 Director 212-07-9825 Maryland Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location r then "neturel", or Iteme 23a or 28a-f ehow the Medical Examinar most be redified at 10d. Inside City Limits 1.☐Yes 2 ☐ No MD Completed by Funeral Director N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 418 N. Montford Avenue 21224 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene Important: if itam 27 is marked other then "neturel", or iteme 23s eny injury or other traumatic event, Ira Medical Examinar must gongs. U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1X Yes 2 □ No If Yes, Give Year or Dates: 1 ₩ Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Stores Appraiser Copper Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John A. Schulz Barbara Herler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John McEvoy /Nephew 6727 Graceland Avenue Baltimore, Maryland 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2000 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) metro Crematory 1/14/06 Baltimore, Maryland 21. Signature of Furtherar Service Licensee 22. Name and Address of Facility Charle S. Zeiler & Son, Inc. 28a. Part. Enter the disease, or complications that caused the death. Shock, or learn failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. (In Seosi's 6224 Eastern Avenue Baltimore, Maryland 21224 Approximate Interval Between Onset and Death Physician /Medical (or as a consequence of): Examiner 4 1 May truct Sequentially list conditions, any leading to innectial cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a r sequence of) or Attending Physician: The law requires that the death certificate be executed use as the burial-transit the attending physicien and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No be detached for Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ፭ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Congestive hearf 4 Unknown 1 Yes 2 No 3 Probably peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy perform 1 ☐ Yes 2 ☐ No 1 Yes 2 X No 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA heral Director: After the filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury death. 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide To the Hospital o within 24 hours aft To the Funeral DI 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO TROY Z006 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ATRICK TROY 1940 EASTERN NEWUE BALTIMORE, MB 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

06-0312 B.K.S JOHN SHARP

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar 00808 1-Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear Physician John Elliott Sharp 1530 P M 2006 /Medical JAN 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4301 WAKEFIELD ROAD APT.5 BALTIMORE CITY If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Pay Year) 1/4/1956 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🛣 M 2 🗆 F 50 214-62-3553 Yrs Maryland Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Iteme 23a or 28a-f ehow the Medical Examiner must be notified at MD N/a Baltimore 1 XYes 2 ☐ No Direct 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 4301 Wakefield Road Apt 5 21216 U.S.A death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours efter 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 0 1 ☐ Yes 2 🔼 No Specify: White þ Specify: 3 XWidowed 4 ☐ Divorced "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) other then Sheet Rock Installer Construction permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygien Important: if Item 27 is marked other the eny injury or other traumatic event, this page. 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lloyd P. Sharp Francis Sharp Julius 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 38 Glenwood Road Apt A Baltimore, Maryland 21221 Frances Sharp Julius 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill 1/19/06 Middle River, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lieensee 22. Name and Address of Facility Miller-Dippel Funeral Home Inc. 6415 Belair Road Baltimore, Maryland 21206 Parh. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or help failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) gastrojutestical hemorrhage **Physician** Upper /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ur as a consequence or): Examine Hospital or Attending Physicien: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): physicien Physician/Medicai the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? į Day 4☐ Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

14€ Yes 2□ No 24a. Was an autopsy performed? certificate 1 Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 1√2 Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) AT SCENE Certification: To 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c, Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending death. To the Hospital or Attendi within 24 hours after death.
To the Funeral Director: A completely filled in by the fu М 1 Tyes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) O.C.M.E JAN. 13, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 PENN STREET, BALTIMORE, MARYLAND 21201 ABIULLAH 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

JAN 1 7 2006

			- State Registrar Amend I 1. Decedent's Name (First, Middle, L			711940801	h eath	2. Date of Death	2006	3. Time of Death	
	Physicia /Medic		James Cl	ark TASS	sallo			JAN. 1	Day Yea 3. 2007	5:40 P M	
*	Examin		4a. Facility Name (If not institution, g 1243 SUGARWOOD	ive street and number) CIRCLE		4b. City, Town, ESSEX	or Location of Dea	th	4c. County of De BALTIMO		
0100	Funeral Director		5. Social Security Number 6. 214 68 0'391 Usual Residence of Decedent	Sex 7. Age (In y.	rs. last birthday) 7 Yrs.	If Under 1 Yea Months Days		. (Month, Day, Y	(ear) 9. B	irthplace (State or Foreign Country)	
	within 72 hours after death with the Maryland ene. than "natural", or Iteme 23a or 28s-f show ha Moulcal Examinar must be notified at	ector	10a. State 10b. County MO Baltin		City, Town or Lo	*				10d. Inside City Limits	
	th with the	Funeral Director	10e. Street and Number 1243 SUGA	ewood circ	LE	10f. Zip Code	221	10g	g. Citizen of What (USA	Country?	
9800	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene . If Health and Mental Hygiene "natural", or Iteme 23a or 28a-f show tem 21 is marked other than "natural", or Iteme 23a or 28a-f show other traumatic event, the Maulcal Examinar must be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puer o Specify:	Specify Yes or No- to Rican, etc.)		lace - American Indian, Ilack, White, etc. cify: White	
21215-0	d within 72 ho giene. er then "netu i the Medical	Completed	15. Decedent's (Specify only highest g		(Give	dent's Usual Occu kind of work doni DO NOT use retir	e during most of wo ed)	rking	Sb. Kind of Busines	,	
yland	2 should be filed and Mental Hygis Is marked other aumatic event, II	To Be C	17. Father's Name (First, Middle, Las Joseph Louis				Hele	me (First, Middle, Ma	CIARK		
e, N	jes 1 end 2 sh of Health and if item 27 is m or other traum	91-	19a. Informant's Name/Relationship Bobbi TASSallo 20a. Method of Disposition 1 □ Burial 2 ▼ Cremation 3	WIFE	723 4 D. Place of Dispo cemetery, crei	PARK H position (Name of matory or other pl	CIGHT'S A	Date 20	c. Location - City of	0 21208 or Town, State	
Baltim	permit. Pages 1 en Department of Heal Importent: If Item 2 any injury or other anges.		4 Donation 5 Other (Spec	city)	2:	2. Name and Addi	ress of Facility J.	7/2006 H	NEH & Mc		
	Physician /Medical Examiner		23a. Park Whiter the disease, or co- shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	mplications that caused the de yone cause on each line. A. Narcotic and Due to (or as a cons	Alcohol			c or respiratory arrest	t,	Approximate Interval Between Conset and Death	
	ate be executed hysicien and the burial-transit	Ilcal Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underfying Cause (Disease or injury that mitiated events resulting in death) Last								
Division of Vital Records, P.O. Box 68760,	or Attending Physician: The law requires that the death certificate be ex biter death. Nector: After this certificate hes been signed by the ettending physicien in by the funeral director, page 2 should be deteched for use as the burial	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fo 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death 3	⊒Ectopic pregnand □ Other (specify)	су		23d. Date of d Month	elivery Day Year	
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0	nding Phys th. : After this e funeral di	Certification: 1	27. Manner of Death 1 Natural 5 Pending 2 Accident investigate	28a. Date of Injury (Month, Day Year)	28h Time o	Pnd 28c. Inju		28d. Describe how		unk	
Ö	y th	III Co	3 ☐ Suicide 6 🛣 Could not determine	be Diese of Johnson	t home, farm, str	reet, factory, office	3	28f. Location (Stree City or Town, S Essex, Balt	et and Number of F State) 1243 Sur imore Count	Paral Route Number. Parwood Circle Ly, MD	
Division	s efter of Dire ed in b	Cer									
Division	To the Hospital or Attending Ph within 24 hours elter death. To the Funerel Director: Alter th completely filled in by the funeral	Medical Ceri	29a. Certifier (Check only one) 1 Cartifying F	Physician: To the best of my kaminar: On the basis of examinar and manner stated.	knowledge, deat ination and/or in	h occurred at the t vestigation, in my	opinion, death occu	e, and due to the caus urred at the time, date	se(s) and manner a and place, and du	as stated. ue to the cause(s)	

_			For State Registrar		of Maryla		artment of tificate of		nd Men		PP () ()		0180
	Physici /Medic		1. Decedent's Name (First, Middle Lillian H.			• • •				Date of Death Month Anuary	15°, 20°	ear)6	3. Time of Death 4:47 P M
	Examin		4a. Facility Name (If not institution, 1908 Battle	Way	imber)	4b. City, Town, or Location of Death Odenton							Arundel
	Funeral Director		5. Social Security Number 364-36-0600	6. Sex 1 ☐ M 2 ☒ F		last birthday)	If Under 1 Yea Months Day		4 Hrs. 8. C Min. Ju	ate of Birth Month, Day, Y Ine 30,	1937	Birthpl Coun Ind	lace (State or Foreign try) 1ana
	Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County Maryland Anne	Arundel	1	ity, Town or Lo Odenton						10	0d. Inside City Limits 1 ☐ Yes 2 🖁 No
	or 28e-	Director	10e. Street and Number 10f. Zip Code								J. Citizen of Wh	at Coun	try?
	death v me 23a	Funerai	1908 Battle		edent Ever in I	J.S. 13.1	Was Decedent of f Yes, specify Cu	L113 Hispanic Origi	in? (Specify	Yes or No-	USA 14. Race -		
	d 2 should be filled within 72 hours after death with the Maryland th and Mental Hygjene. It and Mental Hygjene. The marked other then "natural", or fleme 23a or 28e-f show traumatic event, the Medical Examinar must be not lied at	ρ	1 ☐ Never Married 2 ☐ Marri 3 📉 Widowed 4 ☐ Divorced		fYes, specify Cu ¹□Yes 2XX No		Puerto Rica	n, etc.)	Black, White, etc. Specify: Black				
21215-0036	nin 72 h	Completed	15. Decedent (Specify only highes	t grade completed)		16a. Deced (Give life. I	ient's Usual Occ kind of work don DO NOT use retii	upation e during most or red)	of working	16	b. Kind of Busi	ness/Inc	lustry
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Maryland	id be fill ental H ked oth ic even	To Be	17. Father's Name (First, Middle, I Allen Turner	Last)					's Name <i>(Fir</i> chel E		iden Sumame)		
Mary	2 shou and M 'Is mar		19a. Informant's Name/Relationsh				ng Address (Stree	et and Number	or Rural Ro	ute Number, C			Code)
	1en deat en 2		Laurie R. Cenal 20a. Method of Disposition		20b.		Battle V sition (Name of natory or other pi		nton,		nd ZIII c. Location - Ci		wn, State
Baltimore,	Pages ment of I tent: if it		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	pecify)	State	etro Cr	ematory	Inc. 0			Baltim	ore	, Maryland
Ball	permit. Page Department of Importent: if any njury or angs.		21. Signature of Funeral Service I	or	_	22	Name and Add Crematic 299 Frec	ress of Facility On Societies Ierick 1	ety Of Koad F	Maryl Maryl	and Inc	 vlar	nd 21228
0			23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	complications that	caused the dea each fine.								Approximate Interval Between Onset and Death
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	Examiner	3.	Sequentially list conditions,	b. Due to	(or as a conse		MULTER	ame				- 3	3 AMMIS
10	cate be executed obysicien and the burial-transit	Examiner	Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a conse							_	
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Kud on of	ding Physician: th. : After this certific funeral director.	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin 2 Accident Investig	28a. Date (Mor		28b. Time of fnjury	28c. Inj	4 🔲 Nurs	28d.	5 PAesidence Describe how	injury occurred)
Jak	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: Attercompletely filled in by the fune	Certification:	3 Suicide 6 Could r 4 Homicide determi	28f. L	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	ne Hospita 24 hours ne Funere	edical C	29a Certifier 1 Check only one) 1 Medical I	g Physician: To the Examiner: On the b and mar	a bast of my kn pasis of examination stated.	iowledge death action and/or in	semined at the vestigation, in my	tima, date and opinion, death	place, and do occurred at	he to the eaut the time, date	and place, and	at as str d due to	ated. the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier	2.1.0.			29c. Licer	nse number	-		. Date signed (i		- 001
	5		30. Name and address of person	who completed Call	se of death (Its	m 23a) (Tvne	Print)	114735	7-11		U	- 17	, 2006
	7		Jackin Blakely	mo T	ohn, Ho	ckins	Hospitu	5501	V-HI	Brach	Wy 5	Hin	nar MD212
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DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month **Physician** January 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Irs. 8. Date of Month, HOSPITAL BALTIMORE SINAI OF BALTIMORE If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 218-64-0240 Usual Residence of Decedent Months 1**X**M 2□ F Director たいたら 10a. State 10b. County 10c. City, Town or Location 28a-1 show traumatic event, the Medical Examiner must be notified at Funeral Director Maryland more 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code or items 23a or 2 Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 No Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No à Specify: 3 Widowed 4 Divorced "naturel" Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry KNOWN permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "na any injury or other traumatic event. It a Made once. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) atient (Sister) 19a. Informant's N-me/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other p Balto, Md. 21215 lobin 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility eral Home, P. Balto, Md. 212 Joseph Li Kuss Tur 2222 W. North Ave. 23a. Parn/Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIO **Physician** /Medical Due to (or as a consequence of): Examiner Stag End Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 3 Probably 2 No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? (es 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one 2 No Inpatient 1 Tes Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

10:45 PM

9. Birthplace (State or Foreign Maryland

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

29d. Date signed (Month, Day, Year)

BALTIMORE

Year

4 Unknown

1 XYes 2 No

Year

State Registrar

Medical

VASSILIADES (D. O SINAI 32.º Registrar's Signature

and manner stated

ess of person who completed cause of death (Item 23a) (Type, Print)

JAN 1 7

4 T Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29a Certifier

ORIGINAL

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

000

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death s Name (Fir 3. Time of Death **Physician** 06 urner 7.20 P M /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner Baltimore 5. Social Security Number 7. Age (In yrs. last birthday)
Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country) **Funeral** 6. Sex 1 M 2 F Months Days Hours 579-10-0566 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" --- any injury or other traumatic average. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Bal 1 Yes 2 No Completed by Funeral Director +more 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21208 mora 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done life. DO MOT use retire during most of working Elementary/Secondary (0-12) College (1-4or 5+) dyrs Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Be George 19b. Mailing dres. (Street and Jum 🗸 21208 20a. Method of Disposition

1 Burial 2 Cremation 20b. Place of Disposition (Name of 20c. Location - City or Town, State 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licent m>21133 23a. Part1. Ent the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** accident Con die vin cular 4 month /Medical Due to (or as a consequence of): Examiner nra Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 1 Due to (or as a consequence of): Examiner to the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Premonia - lho Due to (or as a consequence of) Box 68760, Be Completed by Physician/Medical igned by the attending be detached for use as 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Ö 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? mellitim Di Noctus 1 ☐ Yes 2 ☑No 3 ☐ Probably 4 ☐Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an hes autopsy performed? 2 No 1 Yes Division of Vital After this certific funeral director, 25. Was case relerred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No death. within 24 hours efter death.

To the Funeral Director: A completely filled in by the fi 2 Accident 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date liled (Month, Day, Year) 32. P

010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



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R.C

porte

Rimidalls home

D 15434

mel 21133

13/06

	•	1 - For State Registrar	State of M	laryland / De _l <i>Ce</i>	partment of H e <i>rtificate of</i>			iene UU5	00813
		1. Decedent's Name (First, Middle, La	ist)				2. Date of Deat	h	3. Time of Death
Physic		Charles	Edward	Thompson	Sr.		Month January	12, 2006	8:10 p ^M
/Medi Exami		4a. Facility Name (If not institution, gir				or Location of Death		4c. County of De	
LAGIIII	ici	Golden Crest Ass	isted Livi	no	Hamps	tead		Carr	011
Funeral		5. Social Security Number 6.	Sex 7. Ag	ge (In yrs. last birthda	y) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,	9 B	irthplace (State or Foreign
Director		218-22-5581	1⊠M 2□F	78 Yrs.	Months Days	Hours Min.			Country)
D.		Usual Residence of Decedent							3 - 10
irylar show	_	10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
e Ma	5	Maryland Carro	11		Reisterst	own			1 Tes 21 No
5-UUSO 72 hours after death with the Maryland naturel', or Items 23a or 28e-1 show dical Examinar must be notified at	Funeral Director	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What (Country?
23a	le l	1819 Emory Roa	ad		2	1136		U.S.A	•
r dea	ne l	11. Marital Status	12. Was Decedent Armed Forces	?	 Was Decedent of F If Yes, specify Cub 	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - An Black, Wh	nerican Indian, nite, etc.
a after a f		1 ☐ Never Married 2 ☐ Married	1 X Yes 2 ☐ If Yes, Give		1 ☐ Yes 2 ☑ No	Specify:		Specify:	
A 13-00-30 ithin 72 hours aff ie. In a "natural", or Medical Exam	d by	3 ☑ Widowed 4 ☐ Divorced		Korean					White
nat 72 I	Completed	15. Decedent's 8 (Specify only highest gi		16a. Dec	cedent's Usual Occup ve kind of work done i. DO NOT use retire	during most of wor	rking	16b. Kind of Busines	s/Industry
within 9ne. than	E G	Elementary/Secondary (0-12)	College (1-4or	5+)				C== = =	
D . D	ပိ	6 17. Father's Name (First, Middle, Las	t)		Self emp		ne (First, Middle, M	Groc Maiden Sumame)	егу
ntal h	Be	William	Thompson						
inal y call of the filt and Mental Hith and Mental Hit is marked oth treumatic even	으	19a. Informant's Name/Relationship		19h Ma	illing Address (Street		·	City or Town State	Zin Code)
Mith and 2 st			Daughter						
<u> </u>		20a. Method of Disposition	Jaugitei	20h Place of Dis	Emory Ro			Maryland 20c. Location - City of	
3 0		1 Burial 2 Cremation 3		cemetery, c	rematory or other pla				
rtmer rtant njury		 4 □Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice 		ноту сто	ss Cemete:				, Maryland
partill Diagram permit. Pages 1 a Department of Hee Important: If item any injury or othe		21. Signature of Funeral Service Lice	n Jon K	1-1	22. Name and Addre			terstown, eistersto	
		23a. Part 1. Enter the disease, or cor	antiantions that cause						Approximate
		shock, or heart failure. List only	one cause on each	line.	-	_			Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Cere	elrava	soular	acces	lent		1 mel
Examiner			Due to (or as	s a consequence of):	ratue Vi	/	. ,0		2 +1
	_	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	s a consequence ol):	race or	reun	Mises	under	syn
ted	n lu	cause. Enter Underlying Cause (Disease or injury	Dula	1					18/11/1
xecu and	Examlner	that initiated events resulting in death) Last	C. Due to (or as	s a consequence of):		A			10070
cate be executed physician and the burial-transit			Chro	nic Res	ul Far	here			Zun
	edical		d						
death certifi e attending d for use as	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of d	elivery
وَ اللَّهُ عِلَى الْ	cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant a		3 □Ectopic pregnanc 5 □ Other (<i>specify</i>) _	у		Month	Day Year
	hys	9 🗆 Unknown	9□ Unknown						
• £ 2 8	by P	Part II. Other significent conditions	contributing to death	but not resulting in the	underlying cause giv	ven in Part I.	23e. Did tob	acco use contribute	to the cause of death?
w require been sig should b					·		1 □ Y€	es 2. (2 X No 3. □1	Probably 4 □Unknown
2 70	Completed						24a. Was a	n 24b. Were	autopsy findings available
The law requires t rate has been signe page 2 should be o	E						autops perform	ned? death?	
VICAL ician: certifical ector, p	Be C	25. Was case referred to medical				26. Place of Dea	ath (Check only on		0.44
OI VICA Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 € NO	Hospital: 1 🗀 Inpat	ient 2 ER/Outpat	ient 3 DOA Ott		lome 5 🗆 Reside		ecity)
g Phy Gerthi		27. Manner of Death	28a. Date of Inj (Month, D	ury 28b. Time ay Year) Injur	of 28c. Inju	rv at		w injury occurred	Thurst
Attending Ir death. sctor: After	atlo	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation		ay / oa//		Yes 2 □No			The state of
UNISION OF VICE. t or Attending Physician: 1 after death. Director: After this certificat Jin by the funeral director, pa	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	286. Place of Ir	njury - At home, larm, etc. (Specify)	street, factory, office		28l. Location (St. City or Town	reet and Number or I	Pural Route Number,
rs affe	Cer								
To the Hospitel or Attentwithin 24 hours after dealt To the Funeral Director: completely filled in by the	cal	(Check only 2 Medical Exe		t ol my knowledge, de of examination and/or					
To the H within 24 To the F complete	Medical	one)	and manner s						
To To	~	29b. Signature and title of certifier	111-1-		29c. Licens		25	9d. Date signed (Mo	iui, Day, Teari
11		John W.O M	refletin	MD		5443		11/3/2	004
h1		30. Name and address of person who	completed cause of	death (Item 23a) (Typ	e, Print)	, , .	1 4	1	

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

JOHN TIGHE 06-00234 RKD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	Unpend item#23a,27	State of Maryland				nd Mental Hyg	iene	106	00811	
	1 - State Registrar		Ce	rtificate	of Death		leg. No.			
Physician /Medical	Decedent's Name (First, Middle, Last)	John	,	righ e		2. Date of Dea Month JANUARY	Day	2006	3. Time of Dea 2:05P.	
Examiner	4a. Facility Name (If not institution, give s	street and number)		4b. City, To	wn, or Location of E		T	ounty of Deat		
*	6226 O'DONNELL STR				IMORE	Usa Tarana			N/A	
Funeral Director	5. Social Security Number 6. Sex 220-68-3224	7. Ag <i>e (In yrs. li</i> ≩M 2□F 48	ast birthday) Yrs.	If Under 1 Months I		Min. 8. Date of Birth (Month, Day March 3	, Year)		hplace (State or Fo untry) aryland	
within 72 hours after death with the Maryland ene. then 'naturel', or iteme 23a or 28a-1 show the Medical Exercition must be notified at ompleted by Funeral Director	10a. State 10b. County Maryland N/ 10e. Street and Number		, Town or Lo	ocation 10f. Zip C		altimore City 10d. Inside City Limits 1 △Yes 2 □ No 10g. Citizen of What Country?				
3a or	6226 Alumore Way			101. 2.00	212			ted St	•	
be filed within 72 hours after death with the Marylan Hydione. ad other then "naturel", or iteme 23a or 28a-f show event, the Medical Exertiner must be notified at event, the Medical Exertiner must be notified at Be Completed by Funeral Director		12. Was Decedent Ever in U.: Armed Forces? 1 ☐ Yes StylNo If Yes, Give Year or Dates:		Was Deceder If Yes, specify	nt of Hispanic Origin Cuban, Mexican, F	? (Specify Yes or No- Puerto Rican, etc.)	14	. Race - Ame Black, White pecify:	rican Indian,	
ed within 72 houygiene. Ner then "nature t, its Medical E	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		16a. Dece (Give life.	dent's Usual (kind of work DO NOT use	Occupation done during most of retired)	f working	16b. Kind	of Business/	Industry	
Hygiene Hygiene the the the the the the the the the th	7 Years	,	Ma	intenar	nce		Oil	Compa	ny	
z should be lifed will mad Mental Hygiene. I e marked other then sumatic event, the M	17. Father's Name (First, Middle, Last)	ukn.				Name (First, Middle, y Tighe	Maiden Si	umame)	-	
f Heelth and Men them 27 is marks other traumatic	19a. Informant's Name/Relationship (Ty) Mrs. Barbara Tighe	·		-	Street and Number of	or Rural Route Number Road Leon	-			
of the tr	20a. Method of Disposition 1 □ Burial 2 ⊠ Cremation 3 □ R	20b. P	lace of Dispo	esition (Name matory or other	of	Date		tion - City or		
rtmen rtant: sjury	4 Donation 5 Other (Specify) 21. Signature of Joneral Service License	Hi	_			1/13/2006			ryland	
eny tr	Megorn	E. Keel				al Home of Dundalk,			inc.	
thysicien and the burial-transit and the buri	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ		_						
by the attending prached for use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3]Ectopic preg] Other (spec			230	d. Date of deli Month	ivery Day Year	
been signed should be det	Part II. Other significant conditions con	ntributing to death but not resu	ulting in the u	nderlying cau	se given in Part I.		bacco use es 2□I		the cause of death	
certificate hes been s'ector, page 2 should	25. Was case referred to medical					1	sy med? 2 □ No		topsy findings avail completion of cause 2 No	
this certificated rail director.	examiner?	lospital: 1 ☐ Inpatient 2 ☐ I	EB/Outpatier	nt 3 DOA	0.1	Death Check only or ng Home 5 ☐ Resid		Other (See	CENTE	
After In	27. Manner of Death 1 Natural 5 Pending	13.4		Fnd 28c	Injury at Work?	28d. Describe h			unk	
within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building atc. (Specify Found: Resident)					treet and to n, State) City,	eet and Number or Rural Route Number, State) 6226 o Donnell St. City. MD		
within 24 hours after to the Funeral Dir completely filled in Medical Cert	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, deat tion and/or in	h occurred at vestigation, in	the time, date and p my opinion, death	place, and due to the coccurred at the time, o	ause(s) ar ate and pl	nd manner as lace, and due	stated. to the cause(s)	
withir comp	29b. Signature and title of certifier	MA		29c. l	icense number	2	9d. Date :	signed (Monti	n, Day, Year)	
/	Mah	7/1/			.C.M.E.	J.	ANUAF	RY 10,	2006	
\	30. Name and address of person who co	mp ed cause of death (Item	23a) (Type,		ENN STREE	T BALTIMOR	E MAR	RYLAND	21201	
State Registrar	31. Date filed (Month, Day, Year)	32 Hegistrar's Signal	ture	SHE!						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** January 13, 2006 Uhlik 6:20 A Eunice /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Baltimore Co. Gilchrist Nursing Center TOWSON If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 A F Yrs: Director 81 216-18-4491 July 25,1924 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Itema 23a or 28a-f shov The Medical Examinar must be notified at Director Baltimore Eastwood 1 ☐ Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 7131 Eastbrook Avenue United States Funera 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 ☑ No ģ Specify: White 3₺ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation . (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Steel Industry 7 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental Edith Lohman Charles Mahaley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eunice M. Evans (Daughter) 5016 Pilgrim Road Baltimore, Maryland Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 70 important: If it any injury or c once. ₽ Burial 2 Cremation 3 Removal from State 4 □Donation 5 □ Other (Specify) Oak Lawn Cemetery 1/18/2006 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 23a. Part Efficient he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in dealh) ensovascular distase Physician LEVS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 68760. certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) 4☐Pregnant at time of death been signed by the a should be detached Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were aulopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Wasan s certificate has burnector, page 2 s autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Dother (Specify) 1 ☐ Yes 2 No this 28b. Time of 27. Manner of Ceath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Diractor: / 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after ŏ within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated 29b. Signalure and tyle of certifier 29c. License number 29d. Date signed (Month, Day, Year) D58303 30. Name and address of person who completed cause of death (Item 23a) (Type, Pyht)

AAN ONI (IAMWES, M COOL N CUNCES ST Baltoner Um 24dog

State

Registrar

31. Date filed (Month, Ray,

06

32. Registrar's Signature

Bolles .

2006

1/13/06 at 0130 AM Baltimore, Maryland 21215-0036 MARCHRITA VALDIVIA EXPIRATEDIVIA EXPIRATED DIVISION OF VITAL RECORDS, P.O. Box 68760, 6

		For State Registrar	Pleas				d / Depa		leaith a	re All Copie and Mental H	ygien	e 0 0 6	00816	
	Y., "	Negistrar Decedent's Name	e (First, Middle.	Last)			- 001	incate of	Death	2. Date of	Rag.(Ń Death	0000	3. Time of Death	
Physicia /Medic		Marga	rita Val	ldivia						Janua:		3, 2006	1:30 Am	
Examin	er	4a. Facility Name (I			nd number,)		4b. City, Town, o		f Death	4	c. County of Dea		
		5. Social Security N	rist Cer	iter . Sex	7 1	ae (la ure	last birthday)	If Under 1 Year	WSON	24 Hrs 9 Date of I	2idh	Baltimore		
Funeral Director		220-06-3	050	1 □ M 2X		82	**	Months Days		Sirth Day, Year) 9. Birthplace (State or Foreign Country) Peru				
land bw		Usual Residence of 10a. State	f Decedent 10b. County			10c. City	y, Town or Lo	cation					10d. Inside City Limits	
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h the	irec	10e. Street and Nur	mber					10f. Zip Code			10g. C	itizen of What C	ountry?	
th will	ai	9004 Thr	ogmortor	n Road	[21234					P	eru		
eme eme	Iner	11. Marital Status		Am	s Decedent	?	.S. 13. \	Was Decedent of H	lispanic Orig	gin? (Specify Yes or , Puerto Rican, etc.)	No-	14. Race - Am Black, Whi		
should be filed within 72 hours after death with the Maryland nd Mental Hyglene. I marked other than "natural", or Iteme 23a or 28e-f show umatic event, the Medical Exemiter must be notified at	by Funeral Director	1 Never Marri 3 Widowed	ied 2 Married 4 ☑ Divorced	If Y	Yes 2 🔀 es, Give ar or Dates:	No Tax							Hispanic	
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20 = 4 d		Thoma					2	99 Frede	rick I	Roád Balti	more	, Maryl	and 21228	
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ysici is cer direc	ToB	examiner? 1 ☐ Yes 2 🙀	rNo	Hospital	: 1 🗌 Inpati	ient 2 🗆	ER/Outpatien	t 3 DOA Ott	\or	rsing Home 5□Re		6 Sother (Spe	ecity) - Price	
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tendi leath. tor: A the fu	cati	2 ☐ Accident 3 ☐ Suicide	investiga 6 □ Could no	t he				-	Yes 2 □ N					
for At after of Direct	Certification:	4 Homicide	determin	ed 28e	Place of In building, e	ijury - At ho itc. <i>(Specif</i>)	ome, farm, str y)	eet, factory, office		28f. Location City or 1	(Street a rown, Sta	ind Number or R fe)	ural Route Number,	
To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one)	1 Certifying 2 Medical E	caminer: Or	To the besing the basis of manner s	of examina	wledge, death tion and/or in	n occurred at the til vestigation, in my o	me, date and opinion, deat	d place, and due to the the time to the time.	ne cause(e, date ar	s) and manner a nd place, and du	s stated. e to the cause(s)	
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- 5 - 0		DA/	that	hon	y the	ly	· my	107	52	25	J.	MUAVY	13,2001	
h		30. Name and addr	ress of person w	no complet	cause of	de leb	n 23a) (Туре,	Print) 1/	111	0 0	1	01	13,2006	
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		•	For State Registrar	State	of Marylan	•	irtment of F tificate of I		nd Ment	tal Hygier	200	6 (0081	1
	Physici	an	1. Decedent's Name (First, Midd							ate of Death	Day Y	ear	3. Time of Death	
	/Medic		Virginia Lee		7-1-1					nuary 1			7:20 P	VI
	Examin	er	4940 Silver 3	-			4b. City, Town, or Pevry	Hall				imoru imoru	2	
	Funeral Director		5. Social Security Number 220-24-9096	6. Sex 1 ☐ M 2 【▼F	7. Age (In yrs. 77	last birthday) Yrs.	If Under 1 Year Months Days		Min. (A	tate of Birth Month, Day, Yes	1928 g	Birthplace Country	e (State or Foreig Land	J n
	and **		Usual Residence of Decedent 10a. State 10b. Count	у	10c. Cit	y, Town or Lo	cation					10d	. Inside City Limit	s
136	Maryl febo	tor	Maryland Bal	timore			Perru	Hall					1 ☐ Yes 2 X N	
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	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f ehow any injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Ma 3 ☒ Widowed 4 ☐ Divorce	rried 1 Tes	2 No Sive		Was Decedent of H f Yes, specify Cuba I□Yes 2 ¼ No	lispanic Origir an, Mexican, I Specity:	n? (Specify ` Puerto Ricar	Yes or No- n, etc.)	14. Race - Black, Specify:	White, etc		
5-003	72 ho	eted	15. Decede	nt's Education est grade completed	f)	16a. Deced	ient's Usual Occup	of working	16b	. Kind of Busin	ness/Indus	stry		
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Maryland	d 2 sho th and h		19a. Informant's Name/Relation		(dahtr)		ng Address (Street Silver S					-		K
ē,	s 1 an if Heal item 2 other		20a. Method of Disposition		20b. F		sition (Name of natory or other place		Date		Location - Ci			_
altimore,	Page nent o ant: If ury or		1 XBurial 2 ☐ Cremation 14 ☐ Donation 5 ☐ Other (f Faith (/20/20	06 Bal	timore	, Ma	ryland	
Balt	permit. Departr Imports any inje		21. Signature of Funeral Service		aker		Name and Addre							
			23a. Part1. Enter the disease, shock, or heart failure. Li	or complications that	t caused the deat							A	pproximate terval Between	
	Physician		Immediate Cause (Final disease or condition		//	nces	liene						nset and Death	-
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Вох	death certifi attending	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live	birth 2 Feta gnant at time of c	ıl death 3□	Ectopic pregnancy Other (specify)	<u>′</u>		23d. Date of delivery Month Day			ay Year	
P.O.	t the c by the tached	Physician/M	9 Unknown	9□ Unk	nown									
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Division of Vital Records,	he lav e has age 2	Completed				-				24a. Was an autopsy performed	? prid	or to comp ath?	findings availab letion of cause of	е
ital	lan: Trifical	BeC	25. Was case referred to medic examiner?	al				26. Place o		eck only one)	No IL	Yes 2	≥ NO	_
> t	Physician: r this certifica ral director, I	은	1 ☐ Yes 2 ☑ No			ER/Outpatier		4 LI Nuis		5 X Residence				
on C	ding P	tion:	27. Manner of Death 1 Matural 5 □ Pend	ling (Mo	e of Injury onth, Day Year)	28b. Time of Injury	Wor	yat k? Yes 2 ⊡No		Describe how in	njury occurred			
/isi	il or Attendi after death. Director: A d in by the fu	fical	3 ☐ Suicide 6 ☐ Coul	mined 200. Plat	ce of Injury - At h	ome, farm, str	eet, factory, office		28f. L		ation (Street and Number or Rural Route Number,			
Ö	rs afte al Dire	Certification:	4 Homicide	buil	Iding, etc. (Specia	(y)				City or Town, St	ate)			
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier Check only one) Certify	ing Physician: To the al Examiner: On the and ma	he best of my kno basis of examina anner stated.	owledge, deatl ation and/or in	n occurred at the tir vestigation, in my o	me, date and pinion, death	place, and o occurred at	the time, date	e(s) and mann and place, and	er as state d due to th	ed. e cause(s)	
	To t To t	Σ	29b. Signature and title of certif	ier (M 🕥			29c. Licens	e number	,	29d.	Date signed (y, Year)	
f	7		N/A	- 111)			DIG	390/			1/16/0			
1	T T		30. Name and address of person	ANT 9	114 PH.	ILADE	Print) -LPHIA	ROF	17)	BACTI	mdk=	, =	21237	
	Sta Regist		31. Date filed (Month, Day, Yea JAN 1	7 2006	Registrar's Signa	ature	34							

AEM06-00332 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Michael R. Wilson Unpend item#23a,27,28a-f,penMe,C852,2/2/06 II

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. UUG Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician MICHAEL R. WILSON 2: 13 P^M 2006 January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel 8000 Brock Bridge Road Laurel Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) Sex 1 M 2 ☐ F **Funeral** Months 593.16.7541 Yrs. 40 1965 IN Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r then "natural", or iteme 23s or 28s-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 No Director TN CLAY Allons 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9224 Willow GrovE USA Rd 38541 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: WHITE Ď 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry within 72 jes 1 end 2 should be filed within 7 tof Heelth and Mental Hygiene. If item 27 ie marked other then "n or other traumatic event, the Med Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION HEAVY EQUIPTMENT OPERATOR 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ROUALD L. WILSON JUDY LAVENAU 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 end 2 ment of Heelth a ant: if item 27 is 9224 WILLOW GROVE RD ALLONS TO 38541 ROHALD L. WILSON Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of important: if if any injury or conce. 1 Burial 2 Cremation 3 Removal from State BAYVIEW CREMATORY 1.17.2006 BALTIMORE MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Fink FineRAL HemE, P.A. 21. Signature of Funeral Service License ulcore GIEN BURNIE, MID, ZICGI CRAIN HUY Si Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line. 23a. Part1 Immediate Cause (Final disease or condition resulting in death) **Physician** Cocaine Intoxication /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate has been signed by the attending physicien and anding physicien and use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. I been signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2□ No s certificate has I firector, page 2 s 1X Yes 2 🗆 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospitat 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 To ther (Specify) Scene Certification: To 1 ☐XYes 2 ☐ No 28a. Date of Injury Ind (Month, Day Year) | 28b. Time of Injury Work? After thi 27. Manner of Death 28d. Describe how injury occurred 5 Pending 1 Natural 2:00 P M 1 ☐ Yes 2**X** No 1/13/06 investigation Director: / 2 Accident 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 8000 block of Brock 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) determined 4 THomicide Bridge Rd. Laurel, MD Found: in trailer Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signafore and title of pertified 29c. License number 29d. Date signed (Month. Day, Year) 10kpind **OCME** January 14, 2006 ed caluse of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 12 32 Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month De

2006

VOID

CERTIFICATE

06-00819

SEE

CERTIFICATE #

05-43868

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a,27,28a-f,pende,0852,2.2.06 TI State of Maryland / Department of Health and Mental Hygiene () () 6 Michael T. Wingfield 06-0333 AKG 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** January 13, 2006 WIngfield 2:25 P Michael /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2608 Plainfield Road Baltimore County Dundalk | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 1958 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days 1**⊠**M 2□F 217-74-4536 Director Maryland Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow rectified at 1 ☐ Yes 2 X No Dundalk MD Baltimore Direct the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6 the Medical Examiner must be USA 21222 2608 Plainfield Road 23a death Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: within 72 hours efter 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 ö 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☑ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Steel Crane Operator 12 years other 7 is marked othe traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental 90 Margaret P. Pencek Pages 1 and 2 should Floyd V. Wingfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other train 947 Barron Avenue, Essex, MD. 21221 Margaret Wingfield sister Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition January 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Depertment o Important: If eny injury or once. Oak Lawn Cemetery Dundalk, MD. 19, 2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A. 21222 7110 Sollers Point Road, Dundalk, MD. 23a. Part 1. Enter the disease or complications that caused the death. So not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Combined Methadone and Norpropoxphene Intoxication /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Exami resulting in death) Last Due to (or as a consequence of): attending physicien at for use as the burial. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No d 9 Unknown 9 Unknown Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 TYes Were autopsy findings available prior to completion of cause of 24a. Was an pege 2 autopsy pérformed? death? 2 🗆 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) At Scene ို 1XXYes 2 □ No 2 ER/Outpatient 3 DOA this 28a. Date of Injury Fnd 28b. Time of (Month, Day Year) Injury Work? funeral 27. Manner of Death 28d. Describe how injury occurred UNK Certification: After 1 Natural 5. Pending investigation To the nospectory within 24 hours after death.

To the Funerel Director: All 2:15 P 1/13/06 1 Tes 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Route Number, City or Town, State) 2808 PlainField Road 4 - Homicide Dundalk, MD House t Certifying Physician. To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Commonstruction

Commonstruction**

9a. Certifler Medical (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 14, 2006 Misnee 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KOREU 1 ARYDONTS 111 Penn Street, Baltimore, Maryland 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

		1	For Amend Items	State of Maryland, 20b,c per FH,	G851a	rtment of H tificate of t	ealth and N dhb Death	lental Hy	giene	6 0	10822
			Decedent's Name (First, Middle, Last)					2. Date of De Month	Day	Year	3. Time of Death
	Physicia /Medic		Justin Willi	ams				JANUARY	Y 10, 2	006 6	5:24P. м
	Examin	er	ta. Facility Name (If not institution, give str				Location of Death		4c. County	of Death NA	
	F		JOHNS HOPKINS HOSPI 5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday)	BALTIMOR If Under 1 Year	If Under 24 Hrs.	8. Date of Bird (Month, Da	th	ce (State or Foreign	
	Funeral Director			4 2□F 25	Yrs.	Months Days	Hours Min.	Month, Da	1981	Country	MD
	p.		Usual Residence of Decedent	40a Cibi T						100	Lacido City Limita
	anylar show	2	MD 10b. County	10c. City, T		nore				100	d. Inside City Limits 1 Yes 2 No
	28e-1	ecto	10e, Street and Number	2	W.11.	10f. Zip Code			10g. Citizen of V	Vhat Countr	v?
	3a or	Funeral Director	1303 E. Eager :	Street			1205		l	184	
	death	nera		2. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of H	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No	- 14. Race	e - Americar	
92	hours after death with the Maryland tural; or Items 23a or 28e-f show al Examiner must be notitled at	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ∑ No If Yes, Give		☐ Yes 2 No	Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify	-	
Ö	b within 72 hours after death with the Marylan ilens instural; or Items 23a or 28e-f show the Madical Examinar must be notified at		3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education	Year or Dates:	6a Deced	ent's Usual Occup	ation		16b. Kind of Bu		
75	n nat	plet	(Specify only highest grade Elementary/Secondary (0-12)		(Give I	kind of work done of NOT use retired	during most of work	ring			
21215-0036	giene.	Completed	12th grade	4 years		Stu	dent		Edu	catio	NO.
Maryland	be filed hal Hygic od other	Be	17. Father's Name (First, Middle, Last)	•			18. Mother's Nam			e)	
Z	should be nd Mental nmarked umatic ev	၉	Starrley William 19a. Informant's Name/Relationship (Type		10h Mailie	a Address (Street	Janice and Number or Rus			State Zin C	'odol
Mai	A. (G = 2		Janice Williams	1. 6 . 1	130. Maiiin	E. Eag		_	timone		21205
	s 1 end 2 f Health Item 27 l	1	20a. Method of Disposition	20b. Plac		sition (Name of		Date	20c. Location - Baltin		
E	00	١,	1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	moval from State		Qaklawn		Le.05	Khrim	or RA	W MD
Baltimore,	permit. Pag Depertment Importent: I eny Injury o		21. Signature of Funeral Service Licenses	0.	22	Name and Addres	ss of Facility Creene L Road	Funer	al Serv	انحه	
_	20 E 2 9		Mun W.	Suno						1	
			23a. Part1. Enter the disease, or complications, or heart failure. List only one	ations that caused the death. I cause on each line.	Do not ente	er the mode of dyin	ig, such as cardiac	or respiratory a	rrest,	10	Approximate nterval Between Onset and Death
j	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	10	ma	11/9					
	Examiner			Due to (or as a consequer	nce of):	•					
	t	Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequer	nce of):						
	cuted nd ransit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events c.								
00,	cate be executed physicien and the burial-transit	E	resulting in death) Last	Due to (or as a consequer	nce of):						
8760,	physic the b	dlcal	d.								
Ψ	death certifi e attending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregnance					23d. Dat	f. Date of delivery	
Box	death e atter d for u	clar	in the past 12 months?	1 Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat		lEctopic pregnancy Other (specify)			Мо	nth D	Day Year
P.0		hys	9 Unknown	9 Unknown							
	The law requires that the ste has been signed by th bage 2 should be detache	É	Part II. Other significant conditions cont	ributing to death but not resulti	ng in the ur	nderlying cause giv	en in Part I.		tobacco use cont Yes 2 No		bly 4 Unknown
Records,	w requir been si should	eted						10	^		
3ec	has the bas by 30 2 s	Completed						24a. Was auto perfe	psy	Were autops prior to comp death?	sy findings available pletion of cause of
Vital		မ Co	25. Was case referred to medical				26. Place of Dea	1 Yes	2/12/No	1 ☐ Yes 2	P□ No —
Ĭ.	Physicien: this certific ral director,	0 8	evaminer?	ospital: 1 ☐ Inpatient 2 ☐ EF	VOutpatien	t 3💢 DOA Oth	ar		idence 6 □Oth	er (Specify)	
υof		n: T	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (ifficient, Day Year)	8b. Time of Injury	28c. Injur Wor	y at	28d. Describe	how injury occur	red	10
Sio	Attending r death. ector: After by the fune	catle	2 ☐ Accident investigation	1/10/06	745	M 10	Yes 2 No	Sugge	Thans	eds	eld
Division	or Ati	Certification:	Suicide 6 Could not be determined	28e. Place of Injury - At hom- building, etc. (Specify)	e, farm, str	eet, factory, office		City or To	Street and Numb	er or Hural	Houte Number,
П	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	2	29a. Certifier 1 ☐ Certifying Physi	ician: To the best of my knowle	edge, death	occurred at the tir	me, date and place	, and due to the	cause(s) and ma	anner as sta	ted.
	P Fur	edical	(Check only 2) Medical Examin	er: On the basis of examination and manner stated.	n and/or in	vestigation, in my o	pinion, death occu	rred at the time.	date and place,	and due to t	the cause(s)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Me	29b. Signature and title of certifier	^		29c. Licens			29d. Date signe	•	
			1) I kuh	emu)		0.0	.M.E.		JANUARY	11, 2	2006
	10		30. Name and address of person who cor	npleted eause of death (Item 2	3a) (Type,	Print) 111 PENN	STREET I	RAT TTMOR	RE MARY	LAND 2	21201
	<u> </u>		31. Date filed (Month, Day, Year)	32. Redistrar's Signatur	re	TII LEWAN	OTMEET 1	WILLIOI.			
	Sta Regist		JAN 1 7 20	207		bornt 1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieria 1 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year 305 AM JANUARY 13 WILLIAMS MARGARET 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CONTER BALTIMORE JOHNS HOPKING BAYVIEW MEDICAL If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex Months 1 □ M 2 □ F Yrs Jan.18,1938 Maryland 213-36-5971 67 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1900 Grove Manor Road 21221 U.S.A. Apt.425 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Katzenberger Etta unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3813 Birchview Avenue Baltimore, Maryland 21206 Joseph Williams- Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. 1/16/06 Baltimore, Maryland Heather Cain Leonard J. Ruck, Inc. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility leather 5305 Harford Road Baltimore, Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RIGHT SIDED HEART FAILURE disease or condition resulting in death) Due to (or as a consequence of) ACUTE PULMONARY EMBOYSM Sequentiary list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last FALL IN SETTING OF ANTICOAGULATION IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🗖 No 3 ☐ Probably 4 ☐ Unknown CHRONIC OBSTRUCTIVE PULMONARY DISEASE, CHRONIC 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ATMAL FIBELLIATION, HISTORY OF PREMOUS DEET VENEUS autopsy performed THE COMBOSIS CONSESTIVE HEART FAILURE FULTIONARY AYRESTERSON 1 Yes

25. Was case referred to medical examiner?

26. Place of Death (Check only) 2 X No 2□ No 1 Tyes 26. Place of Death (Check only one) Hospital: 1 🗷 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 □Naturai 2 Accident

Examiner iaw requires that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit P.O. Box 68760, been signed by I should be detach Division of Vital Records, certificete hes b irector, pege 2 s : After this certifice funeral director, [Attending Physician: s after den. rai Director: Afr

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Certification: To

Medical

Funeral

Director

r than "natural", or tems 23a or 28e-f show

les 1 and 2 should be filed within 7 of Health and Mental Hygiene. If item 27 ts marked other than "r orther traumatic event, tra Med

permit. Peges 1 Department of H Important: if ite any injury or ot ance.

Physician

/Medical

filed within Hygiene.

Baltimore, Maryland 21215-0036

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 XYes 2 □ No 27. Manner of Death

3 ☐ Suicide

29a. Certifier

5 Pending investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 4 Homicide

HOME

1 ☐ Yes 2 No

multiple fails by home 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1900 GRAG MANOR DE, BALTIMORE

JANUARY

(Check only one) 29b. Signature and title of certifier

29c. License number

RES-000

1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

2006

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BAYVIEW MEDICAL CENTER, BUDMORE, MD 21724

State Registrar

filled in by

within 24 hours a
To the Funeral C

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the Hospital

BENJAMIN 31. Date filed (Month, Day, Year) JAN 1 2008



State of Maryland / Department of Health and Mental Hygiene () Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** E. Dorothea Wise January 12, 2006 9:50 19 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Greater Baltimore Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Maryland 1 ☐ M 2 🗓 F 218-14-8168 83 March 11, 1922 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🔀 No Baltimore Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a or 1211 Lake Falls Rd. 21210 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Maryland 21215-0036 þ Specify: 3 ☐ Widowed 4 € Divorced White Year or Dates: natural Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other then Elementary/Secondary (0-12) College (1-4or 5+) Executive Secretary Development 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth eny july or other traumatic event size. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pauline Mac Knew Harry Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Charles Page/ P.R. 1236 Lake Falls Rd. Baltimore, Md. 21210 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-16-06 Hilltop Service Co. Towson, Md. 21. Signature of Funeral Service Licens 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician DOXIA /Medical Due to (or as a consequence of) Examiner respiratory distress Syndrome Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the burial-transit the attending physicien and Due to (or as a consequence of) Box 68760. Physician/Medical be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) P.O. ል Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ cate has been significated by page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy performed? 1 Yes 24 25. Was case referred to medical 26. Place of Death | Check only one) examiner? Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Injury s efter dec. 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours et To the Funerel D completely filled i Hospital 13 Certifying Physician: To the bast of my knowledge, death control at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifie Medical (Check only one) <u>\$</u> 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 person who completed cause of death (Item 23a) (Type, Print) harles St Suite 550 Towson MD 2/204 32. Registrar's Signature State 2006 Registrar

		1	For State Registrar	State of M	larylan		artment of H	lealth and N Death		jiene 1eg. No. 0 0 (5 00825
			Decedent's Name (First, Middle,	Last)					2. Date of Dea Month		3. Time of Death
	Physicia /Medic		Evelyn M. Wint	erling					January	12, 200	6 10:30 P ^M
}	Examin		a. Facility Name (If not institution,	give street and number,)			Location of Death		4c. County of	
			Franklin Squar			ast birthday)		OSSVille	8. Date of Birtl	2 9	timore
	Funeral Director	1	5. Social Security Number 212–42–8380	1 □ M 2 X F	88	Yrs.	Months Days	Hours Min.	(Month, Day Dec. 12		9. Birthplace (State or Foreign Country) Maryland
			Usual Residence of Decedent						DCC. 12		
	how		10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2X No
	Ba-1 s	2 -		timore		Esse				10g. Citizen of Wh	
;	Nith it		10e. Street and Number				10f. Zip Code	21221		U.S	
	death with the Maryland ms 23a or 28a-1 show froust be notified at	Funerai	8 South Essex	AVENUE 12. Was Decedent	t Ever in U.	S. 13. \	Was Decedent of H	ispanic Origin? (Span, Mexican, Puert	pecify Yes or No-		- American Indian,
		표	1 Never Married 2 Marrie	Armed Forces d 1 □ Yes 2	ίΝο		f Yes, specify Cuba 1 □ Yes 2 XNo		o Rican, etc.)		White, etc.
3	72 hours after death with the Marylan natural; or flems 23a or 28a-1 show sical Examiner must be collified at	by	3 Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			TO THE ZUZANO	Specify:		Specify:	White
2-003	<u> </u>	Completed	15. Decedent's (Specify only highest			(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wor	king	16b. Kind of Busi	ness/Industry
7	d within plene. r than the Ma	m	Elementary/Secondary (0-12)	College (1-4or	5+)	///0. /	Homemake	,		Own Ho	vme.
N	filed within Hygiene. Ither than ent, the Me	e Co	17. Father's Name (First, Middle, L.	ast)		1	HOMOMORE		ne (First, Middle,	Maiden Sumame)	
land	id be ental ked c	To B	John Morgan					Elizab	eth Kerr	ıs	
~	s 1 and 2 should I I Health and Ment Item 27 is marker other traumatic		19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailir	ng Address (Street	and Number or Ru	ral Route Numbe	r, City or Town, Si	tate, Zip Code)
, Mai	and 2 ealth a n 27 is		Evelyn Vogel (Friend)				Road, Es		yland 21	221
ore	0 0 - 1-		20a. Method of Disposition 1	3 □Removal from State	e 20b. P	Place of Dispo semetery, crer	sition (Name of matory or other plac	Jan.	Date		ity or Town, State
altımore,	Pages tment of I tant: If its jury or o		*4 □Donation 5 □ Other (Sp.	ecify)			art Jesus				re, Maryland
E C	pernit. Page Department of Important: If any injury of		21. Signature of Funeral Service L	censee	3,						al Home, P.A. aryland 21221
			23a. Parti: Enl Tile disease, or o	complications that cause	ed the deat		or the mode of duit	on such as cardiac	or respiratory ar	rest	Approximate
			shock, or heart failure. List o	nly one cause on each	line. -Nd	Stag	0 (1.7.	nic Obst	nective	Pulman	Interval Between Onset and Death
ا ج	Physician /Medical		disease or condition resulting in death)	a. Due to (or a		- 3	e coul	MC UNS.	-0(0)(102	diseo	20
	Examiner		Sequentially list conditions	b							
7	p t	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	is a conseq	uence of):					
V	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and Funeral Director: After this certificate has been signed by the attending physician and telliging filled in by the funeral director, page 2 should be detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or a	is a conseq	uence of):					
760,	ate be ex hysician the buria	licai E									
687	ficate p phys	edic		d							
×	that the death certificated by the attending placed by the attending placed for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			∃Ectopic pregnanc	v			of delivery th Dav Year
P.O. Box	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4 Pregnant	at time of d		Other (specify)			Mont	th Day Year
o.	at the i by the etache	Phy	9 ☐ Unknown Part II. Other significant condition			udting in the u	andorhilag causa si	on in Part I	23e Did to	nbacco use contrib	bute to the cause of death?
Ś.	res tha signed I be det	by	C at an attended	A No.	Dut not res	2 9 2 e	- Pul	rongery H	1		3 ☐ Probably 4 ☐Unknown
Orc	w require been sig should b	eted	Aki I Cil	illabia			1.0		24a. Was	an 24h W	ere autopsy findings available
Division of Vital Records,	hash hash ge 2 s	Completed	1)111 21 171	m worten.					autor	osy pri rmed? de	ior to completion of cause of eath?
a	n: Th ficate or. pay	e Co	25. Was case referred to medical					26 Place of Dea	1 ☐ Yes ath (Check only o	237	☐ Yes 2☐ No
Ē	s cert	To Be	examiner? 1 Yes 2 XNo	Hospital:	itient 2] ER/Outpatie	nt 3 DOA Ott	205	1000	dence 6 Other	r (Specify)
10	g Phy ter thi	Ë	27. Manner of Death	28a. Date of Ir		28b. Time o	of 28c. Inju	ry at rk?	28d. Describe	how injury occurre	d
Ö	andin ath. or: Afr	atic	1 XNatural 5 Pending 2 Accident investig	ation				Yes 2 □No			
Ξ	or Atterderinecter	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 28e. Place of I building,	Injury · At h etc. <i>(Speci</i>	ome, farm, st fy)	reet, factory, office		28f. Location (Street and Number vn, State)	r or Rural Route Number,
Ω	urs af		29a. Certifier 1 X Certifyin	g Physicien: To the be	et of my kn	owledge deal	th occurred at the t	me date and place	a, and due to the	cause(s) and man	ner as stated.
	24 ho 24 ho Fun etely (edicai	(Check only 2 Medicel E	Exeminer: On the basis and manner	of examina	ation and/or in	nvestigation, in my	opinion, death occi	urred at the time,	date and place, ar	nd due to the cause(s)
	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	Me	29b. Signature and title of certifier				29c. Licen	se number		29d. Date signed	(Month, Day, Year)
	->-0) Htts	MD			D-	-3875	4	01-13	-2006
	2		30. Name and address of person		of death (Ite	m 23a) (Type	, Print)	BIUD	. 11/1	21	-2006 221
	1		74117	HBRM.	70		SIERN		7 17		
I	St Regist	ate	31. Date filed (Month, Day, Year)	R.	strar's Sign	K. K	barde				

			For State Registrar	State of Mary		artment of H			giene 06	00826
	Physici /Medi	al	Decedent's Name (First, Middle, Las	105	7	4b. City, Town, or	r Location of De	2. Date of Dea Month	Day Year 16 2006 4c. County of Dea	3. Time of Death 12:59 PM
	Examir Funeral Director	er	Mery Medi 0 5. Social Security Number 6. Se	al Cert	yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	TIN If Under 24 F	cons	(, Year) C	thplace (State or Foreign cyland
	Q	or	Usual Residence of Decedent 10a. State 10b. County MD. Baltim		: City, Town or Lo			equence.	19,1919 Mai	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	ith with the h 23a or 28a- ust be notifi	Funeral Director	10e. Street and Number 3146 Cornwall Road			10f. Zip Code 21 22			10g. Citizen of What C	ountry?
980	72 hours after death with the Maryland natural', or tleme 23a or 28a-f show disal Examinar must be notified at	Ď	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	in U.S. 13.	Was Decedent of H II Yes, specify Cuba 1 □ Yes 2ሺ No	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No- uerto Rican, etc.)		
21215-0036	within ene. than *	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 7 years	cation de completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of a	working	16b. Kind of Business Own Home	Andustry
Maryland	should be filed nd Mental Hygin marked other imatic event, I	To Be C	17. Father's Name (First, Middle, Last) Frank Vosteze 19a. Informant's Name/Relationship (7)	vpe. Print)	19b. Maili	ng Address (Street	Marth	Name (First, Middle, a Vosteze	Maiden Surname) r, City or Town, State,	Zip Code)
- 10	of Health ard I so the strain of the strain is other trau		Daniel Yost 20a. Method of Disposition 1 Burial 2 XCremation 3 D	SON 20	3146 Db. Place of Disponentery, cre-	Cornwall osition (Name of matory or other place	Road,	Dundalk,M nuary	D. 21222 20c. Location - City or	Town, Slate
Baltimore	permit. Pag Department Important: I any Injury o		4 Donation 5 Other (Specify. 21. Signature of Funeral Service Licens	1	_	Crematory Name and Address Connelly 7110 Solle	1		Baltimore (Dundalk,P. <i>R</i> Dundalk, Mo	
8760,	Physician // Medical Examiner Physician and Physici	licai Examiner	23a. Part1. Enter the disease of comp shock, or heart lailure. (is only composed to the condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cord.) Due to (or as a cord.) Due to (or as a cord.) Due to (or as a cord.) Due to (or as a cord.)	nsequence of): I C OV Insequence of): Y V V V	SPINX 357AUC LONA C	TOR	DIMON	ilune	Approximate Interval Between Onset and Death JWECKS UNIVERSE UN
P.O. Box 68	death certific e attending p d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 27 No 9 □Unknown	23c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	livery Day Year
	law requires that the as been signed by the 2 should be detache	by	Part II. Other significant conditions on	ontributing to death but no	t resulting in the u	nderlying cause give	en in Part I.		obacco use contribute t	o the cause of death?
Vital Records,	The ate his page	e Completed	25. Was case referred to medical				26 Place of I	24a. Was autop perfor 1 Yes	sy prior to death? 20 No 1 □ Yes	utopsy findings available completion of cause of
Division of Vi	ding Phys	Certification: To B	27. Manner ol Death 15 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Yea		f 28c. Injun Word M 1	er: 4 🗌 Nursın	g Home 5 Resid	lence 6 Other (Speciow injury occurred	
Div	a Hospital or Attenda 24 hours after death Funeral Director: etely filled in by the	ai Certif	4 Homicide determined 29a. Certifier Certifying Phy	building, etc. (S)	oeciły) r knowledge, deat	h occurred at the tin	ne, date and pl	City or Tow	m, State) cause(s) and manner a	s stated.
	To the Ho within 24 To the Fu	Medical	(Check only 2 Medical Examone) 29b. Signature and title of certifier	iner: On the basis of exa and manner stated.		29c. Licens	e number	-	29d. Date signed (Mon	th, Day, Year)
	10		30. Na ly and address of person who c	completed cause of death	(Item 23a) (Type,	Print)	36	NE A	10 2-17	5,2006
100	Sta Registi	ALC: NOTE:	31. Date filed (Month, Day, Year) JAN 1 7 2	32. Registrar's S	Signature _	THE STATE OF THE S	0111	KOIVU YI	iw Inf	2)5

			For State Registrar	State of M	Maryland		artmen rtificate			and M		giene Rag. No.	06	00827
	Physici	an	1. Decedent's Name (First, Middle,	,							2. Date of De.	ath Day	Year.	3. Time of Death
	/Medic	cal	Sharon Kay Yeag 4a. Facility Name (If not institution,				45 035	Y	Location of	10	Jana	7 13	200 6 unty of Dea	
	Examin	ner	Baltimore Washi			nter			urnie				ne Ar	
	. Funeral			6. Sex 7.	Age (In yrs. la		If Under Months		If Under		8. Date of Birt (Month, Da	h		thplace (State or Foreign ountry)
	Director		218-46-5190	1 □ M 2XCXF	57	Yrs.	WOTTE	Days	Tiours	141111.	12-2-1	948	MD	oundy)
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	ocation							10d. Inside City Limits
	Many B-fah	ţō	MD Anne	Arundel	Pa	saden	а							1 □ Yes 2ŽQŽÑo
	or 28.	Director	10e. Street and Number				10f. Zip	Code				10g. Citizen	of What Co	ountry?
,	s 23e		152 Maryland Av					1122				U.S		
Maryland 21215-0036	The state of the s									1	14. Race - American Indian, Black, White, etc. Specify: White			
5-0	72 ho	eted	15. Decedent's (Specify only highest	s Education		16a. Dece	dent's Usua kind of wor	I Occupa	ation	t of workin	a l	16b. Kind	of Business	/Industry
121	ne. han "	Completed	Elementary/Secondary (0-12)	College (1-4c	or 5+)	life.	DO NOT us	e retired)	O HOIKII	'y	_		
9	be filed within 72 hc tal Hygiene. d other than "natu event, the Medical		12 17. Father's Name (First, Middle, L	ast)		Sec	retary	/	18. Mothe	r's Name	(First, Middle,		gal mame)	
an	should be fand Mental Family semanted of umatic even	То Ве	William Noel, S	r.							a Bierm		,	
ary	es 1 and 2 should be filed within of Health and Mental Hygiene. If item 27 is merked other than it other traumatic event, the Mit		19a. Informant's Name/Relationsh			19b. Maili	ng Address	(Street a	nd Numbe	r or Rura	Route Numbe	r, City or To	wn, State,	Zip Code)
ø)	l and fealth im 27 her tr		Mr. Roger L. Ye	ager / hus		152 ace of Dispo			1 Ave		asadena ate			
Baltimore,	perrit. Pages 1 Department of H Important: If ite any injury or ot		20a. Method of Disposition 1X Burial 2 ☐ Cremation		te ce	emetery, crei	matory or or	ther place	·				•	Town, State
量	it. Paramentaria		 4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service L 	the state of the s	Mar	yland	Veter	ans	Cem.	1-18 v Sir	3-2006	Crow	nsvill	le, MD ome, PA
B	Depar Important		> Monka.	Varian	More						en Burn			
	9		23a. Part1. Exter the disease, or of shock, or heart failure. List of	complications that cause on each	sed the death	. Do not ent	ter the mode	e of dying	g, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a. Chron	y ols	Imit	we-	bul	wone	9374	disens	-		Onset and Death
	/Medical Examiner		resolding in dealth)		as a consequ	ence of):		1.		1				
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	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C										
, 0,	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or	as a consequ	ence of):								
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Box 6	eath certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne of pregnar	ncy						234	. Date of de	liven
o.	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burral-transit	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 □ Fetal at time of de		⊒Ectopic pre ⊒ Other <i>(sp</i> e					200.	Month	Day Year
Records, P.	uires that signed b Id be deta	by	Part II. Other significant condition	s contributing to death	n but not resu	lting in the u	nderlying ca	ause give	ın in Part I.		23e. Did to	_		o the cause of death?
CO	s been s	lete									24a. Was	an 2	4b. Were at	utopsy findings available
Re	The lar	Completed									autop	sy	prior to death?	completion of cause of
Vital		BeC	25. Was case referred to medical examiner?						26. Place	of Death	1 ☐ Yes (Check only o	/	1 1 1 1 9 3	2 2 140
of V	Physician: this certific ral director,	은	1 ☐ Yes 2 No	Hospital: 1 Nnpa		ER/Outpatier			4 🗀 Nu		ne 5 ☐ Resid			ecify)
	ing After une	ilon:	27. Manner of Death ↑ Natural 5 □ Pending		njury Day Year)	28b. Time o Injury	f 21	Bc. Injury Work	:?		8d. Describe h	ow injury oc	curred	
Division	en or:	ficat	2 Accident investiga 3 Suicide 6 Could not determit	ot be	Injury - At hor	me, farm, sti			res 2□l		8f. Location (S	Street and N	umber or Ri	ural Route Number.
<u>S</u>	al or safter safter al Dire	Certification:	4 ☐ Homicide determin	building,	etc. (Specify,)	,	,			City or Ton	m, State)		
	To the Hospital or Atti within 24 hours after de To the Funeral Directi completely filled in by t	edical (29a. Certifier 1 Cartifying (Check only one)	Physician: To the be xaminer: On the basis and manner	s of examinati	vledge, deat ion and/or in	h occurred a vestigation,	at the tim in my op	e, date and inion, deat	d place, a th occurre	nd due to the o	cause(s) and date and pla	d manner as ce, and due	s stated. e to the cause(s)
	To the within 2 To the complet	Ž	29b. Signature and title of certifier					License				29d. Date si	gned (Mont	th, Day, Year)
•	0,		TATA	<u> </u>	10			04	-397	7		Kym 61	n 13	2006
	10		30. Name and address of person w	ho completed cause o	death (Item	23a) (Type,	Print)	B	2397	37		1.0	1	
	રું Sta	ite	31. Date filed (Month, Day, Year)	32 Fegi	strar's Signat	yre	- 66	17 24	sind	<u> </u>	ru)	210	011	
	Registi		JAN 1 7	2006	was Si	X A	and I							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amerid 1 tem 8 per 1h 8852 2-2-06 vt

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month sio/Kowski Tosenh 10:55 PM 06 mank 14 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, 4c. County of Death Baltimore Rehabilitation Extended Care Baffimore
If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth 1919 Birthplace (State or Foreign Country) Days Hours 1**x** M 2□ F 86 Yrs 220-07-2461 $2/10/\frac{191}{191}$ Maryland Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits MD N/A Yes 2□No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7848 Eastdale Road 21224 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1≦1Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: White 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Crane Operator American Standard 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden, Surname) John Ziolkowski Martha Kaminska 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Carolyn DiStefano 5903 Lawrence Drive Eldersburg, Maryland 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 1/17/06 Holy Rosary Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatu e of June al Service Licensee 22. Name and Address of Facility Charles S. Zeiler & Son., Inc. 6224 Eastern Avenue Baltimore, Maryland 21224 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, wheart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) on gestive Heart Failure Lyears Section tide with the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical 26. Place of Death Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mapher of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending М 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760, P.O. Division of Vital Records,

Hospital or Attending Physician: The law requires that the death certificate be executed for the detached peeu has certificate After this death the within 24 hours after death To the Funeral Director: ۵ filled the

Physician

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Certification: To

Medical

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

29a. Certifier

(Check only one)

29b. Signature and fittle of certifier

John S. Lake mo 31. Date filed (Month, Day, Year)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

3 4359 (OHIO)

29d. Date signed (Month, Day, Year)

(Earlifying Physicien: To the best of my knowledge, death conumed at the time, data and place, and due to the neuro(s) and manner as stated

ORIGINAL

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		•	1 - For State Registrar	State of Maryland / Depa	rtificate of Death	Reg. 1	/ U U b	00829
		÷e.	1. Decedent's Name (First, Middle, Las	1)		2. Date of Death Month	Day Year	3. Time of Death
3.3	Physici /Medic		Olivia E. Anderson			JAN I		0001 AM
	Examin	· · · · · ·	4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death		4c. County of Death	
		<i>*</i> .	UMMC HOSPITA	L	Baltimore, N		NIA	
	Funeral Director	1	5. Social Security Number 6. Se 217-40-3169 11	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea OCT, 24, 1	9. Birth	place (State or Foreign ntry)
	pu &		Usual Residence of Decedent 10a. State 10b. County	, 10c. City, Town or Lo	cation		· · · · · · · · · · · · · · · · · · ·	10d. Inside City Limits
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	h with th	al Dire	10e. Street and Number	Lanvalo St.	10f. Zip Code 2 / 2 / 7	10g.	Citizen of What Cou	ntry?
036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or Items 23a or 28a-f show says figury or other traumatic event, Ira Medical Exprints rout by notified a proce.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?	Was Decedent of Hispanic Origin? (Spi If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify:	
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lore,	iges 1 ar it of Hea it litem or other		20a. Method of Disposition 1 Burial 2 Cremation 3	20b. Place of Dispo cemetery, crea	sition (Name of matory or other place)	Date 20c.	Location - City or T	Cown, State
Baltimore,	permit. Pe Depertmer Importent eny Injury		4 □Don tion 5 □ Other (Specify 2* Sign > 0 of Funeral Service Licen		2. Name and Address of Facility 6	anklin	ST	265 / 11011
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£		8	23a. Palt1. Enter the clease, or comp shock, or heart foure. List only	dications that caused the death. Do not ent one cause on each line.	er the mode of dying, such as cardiac of	or respiratory arrest,		Approximate Interval Between Onset and Death
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	/Medical Examiner		resulting in death)	Due the (or as a consequence of);				
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Amend item#5, per Init 351 1/24/06 III Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Victorine 0. Adams Tahnery 2006 7:101707 /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Baltimore Roland Park Place If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. lest birthday) Date of Birth (Month, Dey, Year) 04 28 Birthplace (State or Foreign Country)
 MD **Funeral** 218-28-0132 1 M 20 F Director Yrs 93 212-28-0123 Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mentel Hygiene.
Item 27 is marked other then "nature!", or items 23a or 28a-1 show other treumatic event, the Madical Examiner must be notified at XXYes 2□No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Street Apt 404 21211 830 West 40th Funeral U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: ۵ 3 ☐ Widowed 4 ☐ Divorced Specify: Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade 4yrs Civic Leader Baltimore City 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph C. Quille Estelle Tate ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Theo Rodgers-Friend 1040 Park Ave Suite 300, Balto, Md 21201 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If iter
eny injury or ott
once. Date 1

Burial 2 □ Cremation 3 □ Removal from State Arbutus Memorial Park 1/13/06 Arbutus, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21. Signeture of Funeral Service Licensee 21215 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Due to (or as a consequence of): parolid gland 3 months Examiner Examiner sician end buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760, Physician/Medical use as the Due to (or as a consequence of): Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. Division of Vital Records, P.O. ţ, detached 23b. Did tobacco use contribute to the cause of deeth? 1 □Yes 2 □ No signed by 3 ☐ Probably 4 ☐ Unknown þ 8 24b. Were eutopsy findings evailable prior to completion of cause of death? Completed 24a. Wes an eutopsy performed? certificate has 1 1 ☐ Yes 2 NO 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မှ 1 Yes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred Certification: After 1 Natural
2 Accident 5 Pending investigation s efter death. 1 Yes 2 □ No by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours e To the Funerei C completely filled 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Exeminer: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. Medical (Check only 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) り THEGREGOR, 830 W. 40th Street, Backware, Vid 21211 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) LAMBELLE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Agranda) JAN 1 8 2006 Registrar

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Josephine O'Brien Campbell Allen January 14, 2006 8:45 Ам /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Wilson Health Care Center Montgomery Gaithersburg If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 30, 1917 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🖾 F 88 006-16-5362 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Madical Exeminer must be notified at 1 Yes 2 No Directo Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 301 Russell Avenue #418N 20877 or Items 23a United States Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status I □ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced White "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Registered Medical Technologist Medical 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 should be fit and Mental F . Pages 1 and 2 should be treent of Health and Menta tent: If item 27 is marked Mary Abigail Nash Colin Campbell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Weber/Daughter 527 North Jackson, Golden, Colorado 80403 other Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place)
Montgomery Date 20c. Location - City or Town, State 20a. Method of Disposition January 18 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Department of traportent: If any injury or 2009. ō Bethesda, Maryland * 4 Donation 5 Dother (Specify) 2006 Crematorium, Inc. Robert A. Pumphrey Funeral Home/ Chase, Inc. 21. Signature of Funeral Service Licensee M00198 7557 Wisconsin Ave., Bethesda, MD 20814-3501 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final disease or condition resulting in death) we acute cerebrovascular accident **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Be Completed by Physician/Medical the signed by the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 menths?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 1 🗌 Yes 2 PNo 3 🗌 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Urmary 2 No 1 ☐ Yes 2 ☐ No 1 Yes of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Matural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Division or Attending 5 Pending investigation 1 Yes 2 No after death. 2 Accident the 3 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 T Homicide To the Hospital o within 24 hours aft To the Funerel Di completely filled in 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier rung 30. Name and address of person who completed cause of death (Item 23a) (type, Print) HEOBERT BLASCHBACK MI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Howard Barrett Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06-0344 State of Maryland / Department of Health and Mental Hygiene AKG Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 13, 2006 7:23 P M January owar /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Sinai Hospital Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours Min 10 M 2□F 237-52-066 Yrs. Carolina Director North Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at ma Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 412 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, et¢. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Maryland 21215-0036 1 Yes No Specify. Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7 in and Mental Hygiene. Elementary/Secondary (0-12) College (1-4qr 5+) Daltemore uper ison LAth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Vines reeman Scar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) os 1 and 2 sof Health ar ma Haddon Are Da ara m. Danett 4604 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State ö -18-2006 Depertment of Important: If eny injury or one one Volalaun Centi VVIOSAI 4 ☐ Donation 5 ☐ Other (Specify) 21. Signat / e of Funeral Service Licensee Boits, and Frankle elace Cla wallace rineral 21229 ncy mi 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atthroscleration **Physician** Cardiovascul /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) been signed by the s should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of geath? 24a. Was an autopsy death? 1Syes 2□ No performed? Yes 2 No Division of Vital r: Atter this certifice e funeral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XXYes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27 Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation death 1 ☐ Yes 2 ☐ No neral Director: / 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide To the Hospital or within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 14, 2006 D

Registrar

31. Date filed (Month, Day, Year) JAN 1 8 2006

30. Name and address of person who completed

32. Registrar's Signatur

Jause of death (Item 23a) (Type, Print)
111 Penn Street, Baltimore, Maryland

21201

			rtment of Health and M tificate of Death	Reg.	- ZUUh	00834			
Physici		Decedent's Name (First, Middle, Last) Edward George Bloodsworth		2. Date of Death Month January	Day Year 14, 2006	3. Time of Death			
/Medic Examin	1000	4a. Facility Name (If not institution, give street and number) Union Memorial Hospital	4b. City, Town, or Location of Death Baltimore	7	4c. County of Death				
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 08/20/1	9. Birth (Cou 920 MD	pplace (State or Foreign untry)			
e Maryland 8a-f ehow	Director	10a. State 10b. County 10c. City, Town or Loc MD Baltimore City Baltimore	ation			10d. Inside City Limits 12 Yes 2 □ No			
with the a or 2	Dire	10e. Street and Number 3939 Roland Avenue	10f. Zip Code 21210		Citizen of What Cou	•			
ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other then "natural; or Iteme 23s or 28s-f ehow other traumatic event, the Madical Examinar must be notified	d by Funerai	11. Marital Status 12. Was Decedent Ever in U.S. 13. W Armed Forces? 1 Never Married 2 Married 12 Yes 2 No	las Decedent of Hispanic Origin? (Spi Yes, specify Cuban, Mexican, Puerro		14. Race - Amer Black, White	ican Indian, , etc.			
id 21215-0036 filed within 72 hours at Hygiene. other then "natural", or ent, the Madical Exemi	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) 12 (Give k life. D Labore	ant's Usual Occupation ind of work done during most of worki O NOT use retired)	ng	Continen	•			
Maryland d 2 should be flight and Mental Hy ?? Is marked oth traumatic event	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surmame) Catherine Caroline Will								
'e, Mar 1 and 2 sh Health and 1em 27 is m other traum		Sharon C. Baylin /daughter 4303	Norwood Road Balt	imore, MD	21218				
Page Page ment of ant: If ury or		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition cemetery, crem Parkwood	Cemetery	Jan 16 2006 Pa	: Location - City or T				
Balting permit. Pa Departmen Important any injury			Name and Address of Facility remation and Funeral /17 Green Pastures D			ryland 21286-			
Physician /Medical Examiner		resulting in death) Due to (or as a consequence of):	r the mode of dying, such as cardiac of	or respiratory arrest,		Approximate Interval Between Onset and Death 574665			
8/60, rate be executed hysicien and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Cue to (or as a consequence of).	J. Am 29			eday s			
, P.O. BOX 68/60, that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit	Physician/Medicai		Ectopic pregnancy Other (specify)		23d. Date of delik Month	very Day Year			
ecords, P. law requires that as been signed by	þ	Part II. Other significant conditions contributing to death but not resulting in the un-	derlying cause given in Part I.	23e. Did tobace	co use contribute to	the cause of death?			
The The page	e Completed	OF West and the state of the st		24a. Was an autopsy performed	death?	opsy findings available ompletion of cause of			
On Of ding Phyen. After this funerat di	ToB	25. Was case referred to medical examiner? 1			e 6 ☐Other (Speci njury occurred	fy)			
2 p # 2 2	Certification;	3 Suicide 6 Could not be	lined 286. Place of injury - At nome, farm, street, factory, office 28f. Location (Street and Number of Run						
To the Hospital within 24 hours a To the Funeral I	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death Medical Examiner: On the basis of examination and/or invalidation and manner stated.	occurred at the time, date and place, a sstigation, in my opinion, death occurred	and due to the cause ed at the time, date	e(s) and manner as s and place, and due t	stated. to the cause(s)			
To the to the comp	W	29b. Signature and title rediffer A. C. C. C. C. C. C. C. C. C. C. C. C. C.	29c. License number AT 24389 46 -		Date signed (Month,	Day, Year)			
21 8		30. Name and address of Prson who completed cause of death (Item 23a) (Type, PLEV ARABUNOV M.D. UNION I	Memorial Hosp	tul/Bal	E. Brin	MESSIS			
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	E	,					

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible
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	1 - For State Registrar	State of M	iai ylailu / l	Certifica			nd Mei		eg. No.	06	008	35
	1. Decedent's Name (First, Middle,	Last)					2.	Date of Dea Month	th Day	Year	3. Time o	Death
sician edical	Margaret T. Berg	meister					J.	anuary	,	2006	11:30	AM
miner	4a. Facility Name (If not institution,	give street and number;)	4b. City	, Town, or I	Location of	Death	_	4c. Co	unty of Death	1	
roll of	3914 Klausmier F	Road			N	ottin			Bal	timore		
ral		i. Sex 7. Ag 1 ☐ M 2 🖫 F	ge (In yrs. last bii	Months	Days	If Under 24 Hours	4 Hrs. 8. Min.	Date of Birth (Month, Day	Year)	9. Birth	nplace (State untry)	or Forei
or	185-20-4892 Usual Residence of Decedent		77	Yrs.			0	3/09/1	928	PA		
60	10a. State 10b. County		10c. City, Tow	n or Location							10d. Inside C	ity Limit
ţ	MD Baltim	ore	Nottin	aham							1 ☐ Yes	2 <u>2</u> N
Completed by Funeral Director	10e. Street and Number		1100011		ip Code			1	0g. Citizer	of What Cou	untry?	
0	3914 Klausmier R	oad		21	236			1	Inite	d Stat	-08	
Funeral	11. Marital Status	12. Was Decedent Armed Forces		13. Was Dece	edent of His	panic Origi	in? (Specify	Yes or No-		Race - Amer	ncan Indian,	
교	1 ☐ Never Married 2 Marrie					, Mexican,	Puerto Hic	an, etc.)		Black, White		
d by	3 Widowed 4 Divorced	Year or Dates:		1 🗆 Yes	2,24,190	Specify:			Sp	ecify: Whit	te	
Completed	15. Decedent's (Specify only highest	Education grade completed)	16a	Decedent's Usi (Give kind of w	ork done du	uring most o	of working		16b. Kind	of Business/li	ndustry	
du	Elementary/Secondary (0-12)	College (1-4or		life. DO NOT	use retired)	-			Own H	ome		
	17 February Name (First Middle 1 a	2	e Ho	memaker		40 14-15-1			14:4 0			
Be	17. Father's Name (First, Middle, La Frank Adams	ist)						irst, Middle, i	Maiden Su	mame)		
2		. (T				Mary						
	19a. Informant's Name/Relationship Mr. Joseph Bergme		1.0	. Mailing Addres								
	20a. Method of Disposition	- I CCL / II C SDCI		914 Klau f Disposition (Na		Road	Date	-		ion - City or T		
	1 ☐ Burial 2 ☐ Cremation 3		cemete	ry, crematory or	other place			n 17				
	4 □Donation 5 □ Other (Spe 21. Signature of Funeral Service Lie		Chesar	peake Cr		-	20	06 1	Belts	ville, 1	Marylan	.d
Suce	21. Signature of Purietal Service Lin) H M	Million		ion ar	nd Fun	eral A	lterna				
	23a. Part 1. Enter the disease, or co	mplications that cause	of the death. Do							re, Mar	yland Approxima	10
	shock, or heart failure. List or Immediate Cause (Final	nly one cause on each I	line.	s	de or dying	, such as G	ardiac or re	spiratory arr	551,		Interval Be Onset and	tween
an ai	disease or condition resulting in death)	_a. (A _		INDIFF	ERP	W77 1.	TEI				8mt	45
er		Due to (or as	s a consequence	of):								
- L	Sequentially list conditions,	b. Due to fur as	a cuitsequence	υħ								
벁	if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	\										
Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence	of):								
dicai E												
edic		0.								11		
N/S	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d	. Date of deliv	ven/	
Physician/Med	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal death it time of death	3 ☐Ectopic p 5 ☐ Other (s					200	Month	-	Year
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DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Isadore, Blumberg 9:23 AM 2005 JAN /Medical Eacility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Himore NA timole entek 8. Date of Birth (Month, Day, Year) Year If Under 24 Hrs. If Under 1 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Days 12M 20 F Min 213-32-2352 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show or than "natural", or Items 23a or 28a-f show the Medical Evernine must be notified at 1 Yes 2 No Director 3ALTIMORO WOOD LAWA 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after deeth with 7190, 3403 5.A Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 S 2 No U S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 TYes, Give A I Force 1 ☐ Yes 2 ☐ No Specify: þ Specify: whiTe 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 3+r SAKS SALES. MAGAZINE h and Mental Hygier 1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be (3Lumbers ·B cseph 2 Ambach Rose 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) hasfens RD. Este Mo If item 27 I 21214 Joseph 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1-Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. OF 19/06 Faith 4 ☐ Donation 5 ☐ Other (Specify) BALTO. 22 Name and Address of Facility Werral Herre
PAUL STELLA TUNERAL HORRE 21. Sonature of Funeral Service Licenses But Mo 7527 HELERD RD. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician UNG ancer 6 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine the attending physicien and had for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Records, P.O. detached 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1XYes 2 No 3 Probably 4 Unknown has been sig ge 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 2 No 2 No 1 Yes 1 🗌 Yes to the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. mpletely filled in by the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 15, AU41764355 15733 Stoycheff 0 eque Vicholas

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32. Pagistrar's Signature

2006

State of Maryland / Department of Health and Mental Hygiefie | | | | For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** :39 PM JANUARY Margaret Marie Bauhaus 2006 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GLEN BURNIE ANNE ARUNDEL BALTIMORE WASHINGTON MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🔽 F Months Days Hours Director 212-28-0381 75 Oct 7, 1930 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Itsm 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2√ No Director MD Anne Arundel Pasadena 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2038 Poplar Ridge Road 21122 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No by If Yes, Give Year or Dates: Specify: white 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk donut maker pell baking Maryland 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be finent of Health and Mental ! William Benson Jones ٩ Margaret Cecilia Tiernan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 63 Greenwood, VA
of Disposition (Name of Date Regina Paschall/niece 22943 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If It any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) 21. Si multire di Funeral Service Licensee Ronal S. Waylo State Anatomy Board 655 W. Baltimore Street 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. min Baltimore, MĎ Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition **Physician** PNEUMONIA week resulting in death) /Medical Due to (or as a consequence of) Examiner CHRONIC OBSTRUCTIVE PULMONARY DISEASE YPATS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical as the signed by the attending I be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Ulnknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 1 Yes 2 No peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate 210 No 1 ☐ Yes 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) funeral 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification; After 1 Matural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident efter death in by the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Hospitel or 24 hours of s Funeral D 1 [P Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medi and manner stated. ÷. 29b. Signature and title of certifie 29c. License number 2 D 47575 Jack JANKARY 9, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MATTHEW PARK, M.D. 305 HOSPITAL DR. STE. 305. GLEN BURNIE, MD 21061 31. Date filed (Month, Day, Year) State 8 2006 Registrar

06-0298 B.K.S. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a,27, perME, e853,3/8/06 TT State of Maryland / Department of Health and Mental Hygiene BETTY JEAN COOL Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Yeer JAN. 12, 2006 1039 A /Medical Betty Jean Cool 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 332 EAST MAIN STREET FREDERICK EMMITSBURG 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🔀 F Yrs. Director 214-82-5960 North Carolina 45 Jan. 8,1961 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deperment of Heelih end Mental Hygiene. Importent: if Item 27 is marked other then "natural" any injury or other treumatic excessions. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Directo Emmitsburg Frederick Md. 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21727 U.S.A 332 E. Main St Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: .White If Yes, Give Year or Dates: Specify: ģ 3 ☐ Widowed 4 Z Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Manager Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ocie L. Wiles Hobert Bare 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 332 E.Main St. Emmitsburg, Md. 21727 Kenneth L. Cool Jr. (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Jan. 17, Brown Cemetery 4 ☐Donation 5 ☐ Other (Specify) 2006 Foxville, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 12525 Bradbury Ave. J.L. Davis Funeral Home Smithsburg, Md. 21783 MO1414 JANIS Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician a Atherosclerotic cardiovascular disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Dee to (or se a consequence of): Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed ettending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): .O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of performed? draili? 1 Yes VZ Yes 2 🗆 No 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence MOther (Specify) AT SCENE 1∑Yes 2□No Certification: To inis Director: After the 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier and manner stated

State Registrar 29b. Signature and title of certifier

e of death (Item 23a) (Type, Print)

29c. License number

O.C.M.E

111 PENN STREET, BALTIMORE, MARYLAND 21201

29d. Date signed (Month, Day, Year) 13, 2006

JAN.

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		Registrar Decedent's Name (First, Middle, Last	st),		061	incate of	Deali		Date of De			3. Tir	me of Death
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thin 72	Completed	(Specify only highest gra	de completed) Colfege (1-4or 5-		(Give)	kind of work done OO NOT use retin	durina mo	ost of working					
iled wi		12th grade 17. Father's Name (First, Middle, Last)	4yrs		Reco	ord Lib		an her's Name (F	First Middle		ai Hos	spita	<u>al</u>
	To Be	Edward Sheppar						na Br		WIZIOGIT .	Sumame)		
permit. Pages 1 and 2 should be filed within Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than eny injury or other treumatic event, Item 2006.		19a. Informant's Name/Relationship (1	9b. Mailin	g Address (Stree				er, City or	Town, State,	Zip Code)	
t and tealth	-	Barbara McFadde	n-Cousin			East C	olds	pring					21212
ant of h		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific		ceme	tery, crem	atory or other plants					cation - City or		
mit. P pertme portan y injur		21. Signature of Funeral Service Licer		Garr	22	Name and Addr	ess of Faci	ility	4700	OWI	ngs n	1112	, na
RSE S	1	Samo	Glaha	nu	4:	arch F/ 300 Wab	oash_	Ave,			e, Md	21	215
	1	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	plications that caused one cause on each lip	the death. D	o not ente	15	1	-				Interva	ximate al Between and Death
Physician /Medical		disease or condition resulting in death)	a. Due to (or as a	consequence	ce of):	TIC PI	ear	- Ors	ear	e i			
* Examiner		Sequentially list conditions	b		30 01).								
pe tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequenc	ce of):								
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cate be executed physicien and the burial-transit	dical	(d										
entifica ding pt	Med	IF FEMALE:	230 Hugo outcome	4									
v requires that the death certific been signed by the attending probability of the strength of	Physician/Me	23b. Was decedent pregnant in the past 12 months? t □ Yes 2 □ No	23c. ff yes, outcome of 1 Live birth 2 4 Pregnant at 1	Fetal dea		Ectopic pregnand Other (specify)				2	23d. Date of de Month	livery Day	Year
by the crached	hysi	9 Unknown	9□ Unknown										
res the	۾	Part II. Other significant conditions	ontributing to death bu	t not resulting	g in the ur	iderlying cause g	iven in Part	N.			se contribute to		-
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The lay te hes ege 2	d mo			<u></u>					autor perfo	osy omed?	death?		lings available n of cause of
Ital	BeC	25. Was case referred to medical examiner?					26. Płac	ce of Death (0	1 □ Yes Check only o	2 No	1 10:	2 No	
Physic this of	ို	1 Yes 2 No	Hospital: 1 Inpatier		Outpatien	3LI DOA					Other (Spe	cify)	
ding th.: After	tion	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury	28c. Inju We M 1 [unyat ork?]Yes 2.[_ 1	d. Describe l	now injury	y occurred		
r Atter en dea rector by the	Certification:	3 Suicide 6 Could not b	e 28e. Place of Inju		, farm, stre	et, factory, office	9	281	Location (S	Street and	d Number or R	ural Route	Number,
pitel o		500 Carting 15 Carting 15											
To the Hospitel or Attending Physicien: The law requires that the death certific within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier 1 ☐ Cartifying Pt (Check only 2 ☐ Medical Exar	nysician: To the best on ninar: On the basis of and manner star	examination	dge, death and/or inv	estigation, in my	opinion, de	and place, and eath occurred	d due to the at the time,	cause(s) date and	and manner a place, and due	s stated. e to the ca	use(s)
To th Withir To th COMP	Me	29b. Signature and title of certifier	7				nse number			29d Date	e signed (Mon	th, Day, Ye	ar)
		· Com	1100			Mp	0662	206	-	lan	uerry	15/	2006
φ		30. Name and address of person who	completed cause of de	eath (Item 23	а) (Туре,	5401	010	20L	nt of	20	Rundal	2 1000	1133 Md
Stat		31. Date filed (Month, Day, Year)		r's Signature	he .	land !	- 10	,				- 444 1	
Registra	all	JAN 1 8	ZUUD Z	Alle Si	S. A.	Service Comments							

State of Maryland / Department of Health and Mental Hygiene () 00841 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** 3<u>,</u> 2006 7:00 PM M Kenneth V. Clarke January /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 4000 North Point Blvd Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 22, 1938 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1**∑**M 2□ F Months Days Hours Min. Yrs. Maryland Director 219-26-8114 66 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or Items 23a or 28a-f show the Medical Exerciter must be notified at 1 ☐ Yes 2√ No Director Baltimore MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 USA 1305 Blakewood Court Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: Specify: white Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) mechanic bethlehem steel 12 other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy important: If Item 27 is marked oth any injury or other traumatic event Irene Marie Vitak Franklin Leroy Clarke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21222 1305 Blakewood Court Baltimore, MD Elizabeth Clarke/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
State Anatomy Board
Baltimore, MD 21201 once Ronald Wade/ 655 W. Baltimore Street man 28a. Pert Il. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shown or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cardia Physician Sudden /Medical Due to (or as a consequence of): Examiner 0 roncu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events Due to (or as a consequence of) Examiner and Il-transit the death certificate be executed resulting in death) Last Due to (or as a consequence of): the attending physician a hed for use as the burial-Division of Vital Records, P.O. Box 68760, Physiclan/Medlcal IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1∭XYes 2□No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? 1 Yes 2 No certificate 1 Yes 2 No To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 85 au aut Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 Yes 2 No 2 this filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? After t Certification: 1 MNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident To the Funeral Diractor: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) hours after 4 | Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 24 within 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number tun 10,2006 10018744 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Johns Hopkins By Wew Heare at Contra DAVID E KERN MD 4940 Eastern Ave Bellimore MD 21224 B23 31. Date filed (Month, Day, Year) 32. Registrar's Signature State George Registrar 8

DHMH 17 Rev 1/2001

Maryland 21215-0036

Baltimore,

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00842 Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dey January 1/2, 200 Year 7:54 pm Coleman 12,2004 Katherine 4a Facility Name (If not institution, give street end number, 4b. City, Town, or Location of Death Augsburg 5. Social Seturity Number) 161-20-6300 NIA BALTIMORE uther an Home If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (Stete or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Days 1□ M 2X F Months PA 85 07.18.1920 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 20 No MD BALTIMORE WINDSOR MILL 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 3438 21244 RIPPLE ROAD 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 (X) No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 Tes 2 No Specify: Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY FEDERAL GOVT. 121H GRADE NIA 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) MARY MADISON SAMUEL HARRIS 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3438 RIPPLE RD. BALTO. MD JOHN W. COLEMAN (HUSBAND) 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 MCremation 3 ☐ Removal from State 01-17-06 BALTO. MD 4 ☐ Donation 5 ☐ Other (Specify) GREENMOUNT

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral Director

Completed by

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiena. Important: If Item 27 ie marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Experimentment be notified at

Baltimore, Maryland 21215-0036

Examiner Physician/Medical þ Be Completed 2 Certification:

physician and s the burial-transit After this certificata

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: within 24 hours aftar death.

To the Funerel Director: After this certific complataly filled in by the funaral director,

Medical

DIRRULA

1 8 2006

31. Date filed (Month, Day, Year)

21. Signature of Funeral Service Lices	VAU	lame and Address of Facility GHN C. GREEUE F	FUNERAL SERVICE						
7 anoha	515	BALTO, NIGHT PIKE	E BAUD. MD 21229						
23a. Pert1. Enter the disease, or compshock, or heart failure. List only	olications that caused the death. Do not enter one cause on each line.	the mode of dying, such as cardiac	or respiratory arrest,	approximate Interval Between Onset and Death					
disease or condition resulting in death)	a Cokey val	Throm bosis	İ						
resulting in dealing	Due to (or es a conseque	ence of):	1						
C	b	200.00							
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque								
that initiated events resulting in death) Last	Due to (or as a consequence of):								
· ·	d								
Part II. Other significant conditions of	ontributing to death but not resulting in the und	erlying cause given in Part I.		ibly 4 ☐ Unknown					
			performed? avail	e autopsy findings lable prior to pletion of cause eath?					
			1 Ves 2 No 1	Yes 2□ No					
25. Was case referred to medical		26. Place of Deat	th (Check only one)						
examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3□ DOA Other: 4 Lursing Ho	ome 5 ☐ Residenca 6 ☐ Other (Specify)						
27. Manner of Death 1 Netural 5 Pending 2 Accident investigation	28e. Date of Injury (Month, Dey Year) 28b. Time of Injury	28c. Injury at Work? M 1 Yes 2 No	28d. Describe how injury occurred						
3 Suicide 6 Could not b		et, factory, office	28f. Location (Street and Number or Rural City or Town, State)	Route Number,					
29a. Certifier (Check only one)	nysician: To the best of my knowledge, death on the basis of examinetion and/or inversand menner stated.	occurred at the time, date end place, stigation, in my opinion, death occur	and due to the ceuse(s) and manner as sta red et the time, date and placa, end due to	ted. the cause(s)					
29b. Signature and title of certifier	200	29c. License number	29d. Date signed (Month, D	ZUO6					
30. Name and address of person who	completed cause of death (Item 23e) (Type, P	rint)	- 5.5						

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Registrar

MM

Registrer's Signature

MAIN Sheek

21136

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Francis Cavey 5:20 a. January 16, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Catonsville Mariner Health of Catonsville Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10XM 2□ F :70 Director 214-22-9356 November 19, 1926 Usual Residence of Decedent Maryland with the Maryland 10c. City, Town or Location 10a. State other than "natural", or itams 23a or 28a-f show 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 781 Oella Ave 21043 filed within 72 hours after death Funeral U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 Mes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Janotorial unk. Janitor 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any july or other traumatic avant 2008: 18. Mother's Name (First, Middle, Maiden Surname) Be 2 William Millard Cavev Maria Addison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Donna Cavey 781 Oella Ave Ellicott City, Maryland 21043 Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Crest Lawn Memorial Gardens 22. Name and Address of Facility 01/20/2006 Marriottsville, Maryland 21. Signature of Funeral Service Licensee Slack Funeral Home, P.A. 3871 Old Solumbia Pike Ellicott Sity, MD 21043 n1. Enter the disease, or amplications that caused the death. hock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Betwee Onset and De Implediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed attending physicien and for use as the burial-translt Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown should I Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death? certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 1 ☐ Yes 2 No 2 1 Inpatient Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA this : After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No actor: the 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ä within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygien@ 🗍 🛭 🖔 00844 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Yeer **Physician** Lenore 01ga Dossett Jan. 4, 2006 11:50 pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Randolph Hills Nursing Home Wheaton Montgomery If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 79 Feb. 577-40-2958 Yrs. Director 1926 Tampa, Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or Iteme 23a or 28a-f ehow the Medical Examiner must be notified at Silver Spring 1 □Xes 2 □ No Director Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 1600 Northcrest Drive 20904 deeth . Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: t√ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: þ 3 ☐ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry within 72 t 12 should be filed within and Mental Hygiene. Elementary/Secondary (0-12) Coltege (1-4or 5+) Disabled n/a 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be Department of Heelth and Mental Importent: If Item 27 is marked of eny Injury or other traumatic eveny Injury or other traumatic eveny. Rudolph Dossett Mabel Y. Meeker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Harris/Niece 1132 Levine Drive, Santa Rosa, CA 95401 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 1/7/06 Beltsville, MD 22. Name and Address of Facility Rapp Funeral and Crémation Services 1400382 · Daoterneuer 933 Gist Avenue Silver Spring, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Stroke /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <u>Seizure Disorder</u> Examiner Due to (or as a consequence of death certificate be executed use as the burial-transit Mental retardation (mild) and Due to (or as a consequence of): Box 68760, the attending physiclen Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ō Month Year Day 5 Other (specify) P.O. detached 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à of Vital Records, cete hes been sig. 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate funeral director, pag 1 Yes 2 No Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 2X No 1 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No deeth. To the Funeral Director: completely filled in by the t 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1/5/06 D56691 30. Name and address of person who completed cause of death (trem 23a) (Type, Print) Ghousia Sultana 12107 Heritage Park Circle, Silven Spring, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

		1	For State Registrar	State of M	laryland / D	•	ment of H		ind Me		jienę leg. No.	006	00845
- 2			Decedent's Name (First, Middle, La	st)					2	2. Date of Dea Month	th Day	Year	3. Time of Death
	Physici /Medic			Salli	e:	Dorse	еу			1	8	2006	2:45 P. M
	Examin		4a. Facility Name (If not institution, give	e street and number)	4	b. City, Town, or	Location o	f Death		4c.	County of De	ath
			Genesis Long Gr		// / /	15 at a 1 1	Balto f Under 1 Year	If Under 2	24 Hrs 0	Data of Right		N/A	
	Funeral Director		5. Social Security Number 6. S 218-16-0948	M 2 1 F	ge (In yrs. last birt 86		Ionths Days	Hours	Min.	B. Date of Birth (Month, Day 8-2-1	(Year)	9. 6	irthplace (State or Foreign Country) N.C.
- L	Ar .		Usual Residence of Decedent							<u> </u>			
	urylan show		10a. State 10b. County	/ -	10c. City, Towr	or Locat	ion						10d. Inside City Limits XXYes 2 □ No
	Ba-f	Director		N/A	Balto						10- 01		
	with t		10e. Street and Number 803 Mckim Stre	et .		ĺ	10f. Zip Code	21202	!			zen of What (S. A	Country?
	ne 23	era	11. Marital Status	12. Was Deceden		13. Wa	s Decedent of Hi es, specify Cubar			rfy Yes or No-		14. Race - An	nerican Indian,
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any njury or other traumatic avant, the Medical Exambar must be notified at once.	by Funeral	1 Never Married 2 Married	Armed Forces 1 Yes 25 If Yes, Give			es, specify Cubai Yes 2 No		, Puerto Ri	can, etc.)		Black, Wh	nite, etc.
8	ural',	d b	3 ∰Widowed 4 □Divorced	Year or Dates	:								ack
<u>1</u>	n 72 h	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a.	(Give kin	it's Usual Occupa ad of work done of NOT use retired,	ation fu <i>ring most</i>	of working	7	16b. Kii	nd of Busines	s/Industry
712	l withi	mo	6th grade	College (1-4o	N/A		nemaker	,				Home	
פר	al Hyg othe	BeC	17. Father's Name (First, Middle, Last)	14/ 23			18. Mothe	r's Name (First, Middle,	Maiden	Sumame)	
<u> a</u>	Menta	10	Willie West					Anna	Arr	ington			
Maryland 21215-0036	2 sho and is mu		19a. Informant's Name/Relationship	* .		_	Address (Street a		r or Rural	Route Numbe	r, City o	Town, State,	, Zip Code)
e,	s 1 and 2 if Health a itsm 27 is other trai		Latefa Dorsey - 20a. Method of Disposition	Daugnte	r 20b. Place of		icKim St	reet	Balt Da	o, Md			or Town, State
Baltimore,	ages nt of I t: If its / or o		1 ☑ Burial 2 ☐ Cremation 3 [cemeter	y, cremat	ory or other place ial Par		-9-20				own, Md
틀	ortan		4 ☐ Donation 5 ☐ Other (Special Service Lice				lame and Addres			arch F		West	Jown, Flu
B	Dep Impo		Tall W	aril				4300		ash Ave		Rolt	o. Md
			23a Part 1. Enter the disease, or conshock, or heart failure. List only	plications that caus	ed the death. Do r	not enter	the mode of dying		cardiac or	respiratory ar	rest,	—— Dart	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. End	Stage	Con		عوده					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	is a consequence	of):							C) W
я	A	-	Sequentially list conditions,	b. Harris in in	s a consequence	SWY	<u> </u>						Unknin
1	nsit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (01 8	a consequence	017.							
·	be executed sicien end burial-transit	Exar	that initiated events resulting in death) Last	c. Due to (or a	s a consequence	of):							
8760,	cate be chysicie the bur	dical	(d									
9	death certificate be executed e ettending physicien end of for use es the burial-transit	Med	IF FEMALE:										
Вох	eath certific ettending pl	Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal death		ctopic pregnancy				1	23d. Date of d Month	lelivery Day Year
0.	at the de by the e	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4∐Pregnant 9□Unknown	at time of death	5 📙 C	other (specify)						
<u>α</u>	de de		Part II. Other significant conditions	contributing to death	but not resulting i	n the unde	erlying cause give	en in Part I.		23e. Did to	bacco u	ise contribute	to the cause of death?
rds,	n sign	d by	Denertia.							1 🗆 Y	'es 2]No 3□	Probably 4 Unknown
of Vital Record	s been si	Completed								24a. Was		24b. Were	autopsy findings available
Be	The lav	E O					<u>-</u>			autop perfor 1 ☐ Yes		death	o completion of cause of ? es 2□ No
ital		BeC	25. Was case referred to medical examiner?					26. Place	eath	Check only o			
<u>></u>	× 5	2	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpa			3□ DOA Cth	4 NU	rsing Hom	e 5 Resid	dence	6 □Other (Sp	pecify)
	ling P	inol	27. Man of Death 1 ✓ Natural 5 ☐ Pending			Time of Inju ry	28c. Injun Work			3d. Describe h	now injur	y occurred	
Division	death death stor: ,	cat	2 Accident investigation 3 Suicide 6 Could not	De 290 Place of	Injury - At home, fa	arm stree		Yes 2		Rf Location /S	Street an	d Number or	Rural Route Number,
Ď	after Direction by	Certification:	4 ☐ Homicide determine	building,	etc. (Specify)	arm, 5000	t, ractory, office			City or Ton			ridial riodio ridinoor,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical C	(Check only 2 Medical Ext	hysician: To the be	of examination ar	e, death o	occurred at the tin	ne, date an pinion, dea	d place, ar	nd due to the d	cause(s)	and manner I place, and d	as stated. ue to the cause(s)
	o ths ithin 2 o ths	Med	one) 29b. Signature and title of certifier	and manner	stated.		29c. Licens	e number			29d. Dat	te signed (Mo	onth, Day, Year)
	⊢≯Fŏ		1	7	~~~		72000	Y. c			- X	2018	
7	Λ		30. Nam ress of person who	completed cause of	f death (Item 23a)	(Type, Pr	int)		<u> </u>]			
	7		Dilicet Sul	سآد ا	1821 12	eust	metra	Re	B	+12	M	21	215
	St Regist	ate	31. Date filed (Month, Day, Year) JAN 1 8	32/Aegi	strar's Signature	Lea	Min 1						
100	negisi	ावा -		July 1	96 Just 3 145	1							

			For State Registrar	State of M	aryland / De _l	partment of F ertificate of			ene 0 0 6	00846
	Physicia /Medic		Decedent's Name (First, Middle, Joseph	George	DiMattei	, Jr.		2. Date of Death Month January		3. Time of Death 2:21 P ^M
	Examin		4a. Facility Name (If not institution, Franklin Square			4b. City, Town, o	r Location of Death		4c. County of Death Baltimor	
Š.	Funeral Director		5. Social Security Number 213-48-0037	3. Sex 7. Ag 1 X M 2 □ F	ge (In yrs. last birthda 57 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Oct. 22,	Year) 9. Birth Cou 1948 Ma	place (State or Foreign ntry) ryland
	and w.		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Mary a-f sho	tor	Maryland Baltin	more Co.	Ros	edale				1 ☐ Yes 2 🕅 No
	h with the	al Director	10e. Street and Number 7227 Hilltop	Avenue		10f. Zip Code 21	237	10	g. Citizen of What Cou United St	
5-0036	72 hours after death with the Maryland natural; or Items 23s or 28s-f show diest Examinational by notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 🛣 Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces; d 1 Tyes 2 M If Yes, Give Year or Dates:	Ever in U.S. 13	3. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 🕅 No	Hispanic Origin? (Sp an, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: Wh	etc.
21215-0	- 8	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or	(Gi	cedent's Usual Occup ve kind of work done DO NOT use retire Carpenter	during most of work d)	ing	6b. Kind of Business/Ir	•
Maryland 2	s 1 and 2 should be filed withir f Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the M	Be	17. Father's Name (First, Middle, L		C n		18. Mother's Nam	e (First, Middle, M	aiden Sumame)	
<u> </u>	2 should be and Mental is marked is umaric ev	ဥ	Joseph George			uling Address (Street	Brenda and Number or Rur		City or Town, State, Zij	p Code)
, Ma	s 1 and 2 soft Health are item 27 is cother trau		Mrs. Bernadette Dil		-	7 Hilltop			e, Maryland	
Baltimore,	ges 1 a t of He if item or oth		20a. Method of Disposition 1 X Burial 2 Cremation	3 □Removal from State	cemetery, c	position (Name of rematory or other pla	ce)		Oc. Location - City or T	
Iţim	permit. Pages Depertment of Important: If It any injury or o		4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service L	**		of Faith 22. Name and Addre			Baltimore, 5305 Harfor	
Ba	Depre impo		1.00C.C	-7. /·	L. Garapp		J. Ruck,		Baltimore,	
	Physician		23a. Part1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final disease or condition	nly one cause on each I	ine.		_			Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)		a consequence of):	10 CARDA	n			9105
30	Pe sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	U	o Lo N s a consequence of):	CANCE				1107
	be executed ician and buriat-transit	Examin	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					
68760,	m v =	cal	1	d						
_		eq	IF FEMALE:							
P.O. Box	The law requires that the death certificate has been signed by the attending I hage 2 should be detached for use es	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	у	13	23d. Date of deliv Month	ery Day Year
ds, P	luires tha signed I ild be det	ρ		(EO ARTH	RITIS	underlying cause gr	ven in Part I.	23e. Did toba	acco use contribute to to	he cause of death?
Division of Vital Records,		Completed		B BACCO 1	Ary E			24a. Was an autopsy perform	prior to co	opsy findings available omptetion of cause of
/ital	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	11 5.1				h Check only one	-	
3 5	Physicia r this cert ral direct	: To	1 Yes 2 No	Hospital: 1 Inpati		IGHT 3LI DOA		ome 5 Resider	nce 6 Other (Speci	fy)
io	Attending Physician: r death. ector: After this certifice by the funeral director. I	atlon	1 Natural 5 Pending investig	(Month, Da	ay Year) Injur	y Wo	rk? Yes 2 No	Edd. Doddino Hov	w with y occurred	
Divis	if or Attendi after death Director: A d in by the fu	Certification;	3 Suicide 6 Could n 4 Homicide determine	ned 288. Place of In	njury - At home, farm, tc. (Specify)	street, factory, office		28f. Location (Stre City or Town,	eet and Number or Run State)	al Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physicien: To the best xaminer: On the basis of and manner s	of examination and/or	eath occurred at the training of the state o	me, date and place, opinion, death occur	and due to the cau red at the time, dat	use(s) and manner as s te and place, and due t	stated. o the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	1 0-	. 140	29c. Licen:	se number	29	d. Date signed (Month,	
	9		> Whail (NV)	who has	m M()	D-,	48025		1-16-2	2005
1	<i>U</i> *		30. Name and address of person v	PARNI, Mi) 1224	pe, Print)	tru Ave	BALTO	, MD 212	37
6	Sta Regist		31. Date filed (Month, Day, Year) JAN 1	8 2016	trar's Signature	freet.				

68760,	
P.O. Box	
Records,	
of Vital	
vision (

		State of Maryland / Department of Health and Me 1 - For State of Maryland / Department of Health and Me Certificate of Death	(UU5 UU64/
		Decedent's Name (First, Middle, Last)	Reg. No.	3. Time of Death
Physic /Medi		Edwin G DUNCAN	January D	12, 2006 3:10 PM
Exami		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		c. County of Death
	The state of	Sinai Hospital of Bultmore Bultimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8	8. Date of Birth	9. Birthplace (State or Foreign
Funeral Director		224-26-2896 12M 20 F 8 Yrs. Months Days Hours Min. 5	- (Month, Day, Year	Country) (/A.
pug *	1	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
with the Marylan a or 28a-1 ehow	ţ			1 Tes 2 No
th the or 28a	Director	10e. Street and Number 10f. Zip Code	10g. C	itizen of What Country?
ath wi				USA
ter de item	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Marned 1 Forces? 1 Never Married 2 Marned 1 Forces 2 No U.S. If Yes, specify Cuban, Mexican, Puerto Ri	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc.
72 hours after death with the Maryland naturel; or Itema 23e or 28e-f ehow disal Evanuer met be redified at	by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: NAUY 1 ☐ Yes 2☐ No Specify:		Specify: Luhite
natur	Completed	15. Decedent's Education (Specify only highest grade completed) (Size kind of work done during most of working life. DO NOT use retired)	g 16b.	Kind ol Business/Industry
withir iene.	ошо	Elementary/Secondary (0-12) College (1-4or 5+) NA ENGINER		RAILRAD
be filed within ital Hygiene.	BeC		(First, Middle, Maide	
2 should be filed within and Mental Hygiene. Is marked other than aumatic event,	To	Unknown Unkn		
c, man y and 2 should f Health and Mer Itam 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural) 2254 DRUID PARK	2	or Town, State, Zip Code)
s 1 and if Health itam 27 other to		20a. Method of Disposition 20b. Place of Disposition (Name of Complete Vision		Location - City or Town, State
nit. Pages artment of ortant: If it ortant: Or injury or o		4 Donation 5 Other (Specify) GARCLENS' of FA. +6		Alta. Ms.
permit. Pages 1 and 3 Department of Health Important: if item 27 eny injury or other tr.		21 Signature of Funeral Service Licensee 22. Name and Address of Facility 5 Tells 13. Name and Address of Facility 5 Tells 13. Name and Address of Facility 5 Tells 13. Name and Address of Facility 5 Tells 13. Name and Address of Facility 5 Tells 13. Name and Address of Facili	ella Funei	21274
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition Chronic Obstructive Pulmo	wary Die	Sease 10 years
/Medical Examiner		resulting in death) Due to (or as a consequence of):	U	
****	Jer	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):		
ocuted nd transit	Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.		
cete be executed physicien and the burial-transit				
thy cate	edical	d		
th cert	an/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of delivery
w requires that the deeth certifications is greed by the attending is should be detached for use as	Physician/Me	in the past 12 months? 1		Month Day Year
thet if	by Ph		23e. Did tobacco	use contribute to the cause of death?
en sign	ed b	Coronary Artery Disease	1 Yes	2 No 3 Probably 4 Unknown
2 8 8	Completed	Diabetes Mellitus	24a. Was an autopsy	24b. Were autopsy lindings available prior to completion of cause of
ulcian: The certificate I rector, pag	1 .		performed? 1□ Yes 2□N	
ysicial ysicial s certi	o Be	examiner? Hospital: 1 Thepatient 2 DEB/Outpatient 3 DOA Other: 4 DAyroing Hom		6 ☐Other (Specify)
ding Phys	on: T		8d. Describe how in	
ttendi death. stor: A	icati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28e.	Pl Location (Street	and Number or Rural Route Number,
afor A after after Direct	Certification:	4 Homicide determined building, etc. (Specify)	City or Town, Sta	
To the Hospital or Attending Physician: The law requires that the deeth cartification at the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical C		nd due to the cause(d at the time, date a	s) and manner as stated. nd place, and due to the cause(s)
o the vithin 2 o the	Med	one) and manner stated. 29b. Signature and title of certifier 29c. License number	29d. D	ate signed (Month, Day, Year)
/		Denouit, MBBS Res 000	10	nuary 13, 2006
15		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	stital	of Raltingovo
St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	FIRM	Justinic
Regist				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar	State of Marylar		artment of H			giene Reg. No.	06	0081	48	
		1. Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	Year	3. Time of		
Physici /Medi		Carl C. Domanski					JWOAKY	06	2006	10:15	AM	
Examir		4a. Facility Name (If not institution, give s			4b. City, Town, o	or Location of De	eath		ounty of Death			
P > *		Franklin Square Ho	spital Center		Rosed	ale			altimo	re		
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year Months Days		In. 8. Date of Bir (Month, Da	th y, Year)	9. Birth	place (State ontry)	or Foreign	
Director		Usual Residence of Decedent	79	Yrs.			Nov 4,	1926	Mary	land		
and w		10a. State 10b. County	10c. C	ity, Town or Lo	ocation					10d. Inside C	ity Limits	
Mary feh	ō	MD		Balti	more					1 ∏ Yes	2 🗆 No	
28a	Pec	10e. Street and Number			10f. Zip Code			10g. Citize	n of What Cou	ntry?		
3a or	0	9106 Deborah Road				21236		-	USA	,		
2 should be filed within 72 hours after death with the Maryland and Merial Hygiene. Is marked other then "natural", or Itema 23s or 28s-f show raumatic event, the Medical Examinational be collided at	Funeral Director		2. Was Decedent Ever in U	J.S. 13.	Was Decedent of I		' (Specify Yes or No uerto Rican, etc.)		. Race - Ameri			
after a	Ē	1 ☐ Never Married 2 ☒ Married	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give				uerto Hican, etc.)		Black, White,			
ours a	by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates: 143	-46	1 □ Yes 2∏ No	Specify:		S	pecify: wh:	ite		
72 ho	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)		dent's Usual Occup		workina	16b. Kind	of Business/In	ndustry		
igh of the	Jqn	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d) -						
ygier rt.		12	4	mecha	anical en				een Pro	oving (3rd	
be fill	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name							ımame)			
Mer Mer nark	2	Chester Domanski	2:0				es Parzyn					
12 sh n and n and raum		19a. Informant's Name/Relationship (Type Laura Domanski/sp					Aural Route Number altimore,			p Code)		
s 1 and 2 should be filed within 72 hours after death with the Maryla f Haalth and Merial Hygiene. Item 27 Ie marked other then "netural", or Itema 23a or 28a-f ehov other traumatic event, the Medical Examinations is confilled at		20a. Method of Disposition			osition (Name of	. Koau D	Date Date	, MD 21236 20c. Location - City or Town, State				
Pages nent of h int: If ite		1 ☐ Burial 2 ☐ Cremation 3 ☐ R	1		matory or other pla	ce)	Date	200. E00a	don'- City of 1	own, State		
t Partmer		4 ∑Donation 5 ☐ Other (Specify)	1	l a								
permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other tra		21. Signalus of Funeral Service License Ronal Service License	ade, tirecto	r St	2. Name and Addre tate Anat lltimore,	omy Boa	rd 655 W. 201	Balt	imore S	Street		
by Social Control Cont	al Examiner	23a. Pant T. Enter the disease, or complication of the control of	Due to (or as a conse	quence of): PLILIN quence of): PRT A	LURE MONAKY 1					Approximatinterval Bet Onset and I	tween	
phys s the	dical	d										
Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physicien and rail director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)							23d. Date of delivery Month Day Year		
s that	by PI	Part II. Other significant conditions con	23e. Did t	obacco use	contribute to t	he cause of c	death?					
require require sen slg		ASCITES					18	Yes 2X	No 3 ☐ Prol	bably 4 □l	Jnknown	
sho sho	Completed	HYPERTENSION	24a. Was	an	24b. Were auto	posy findinas	available					
he la e ha:	E	ATRIAL FIBI	PHIATION				 autor perfo 	osy ormed?	prior to co death?	impletion of c	ause of	
ifficet or, p	Ö	25. Was case referred to medical	NILLATITU'N			26 Place of I	1 ☐ Yes Death (Check only of	2 No	1 ☐ Yes	2 X No		
/slcik	To B	examiner?	ospital: 1 Inpatient 2	ER/Outpatier	nt 3 DOA Ot	305	g Home 5 ☐ Resi		Other (Speci	6e)		
eral Fr	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o			28d. Describe			7)		
ath. T: Afte	atlo	1 Natural 5 Pending 2 Accident Investigation	(Month, Day Fear)	Injury		rk? Yes 2∐No						
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:	2 Supide 6 Could not be						f. Location (Street and Number or Rural Route Number, City or Town, State)				
To the Hospital within 24 hours a To the Funeral Completely filled	edical (29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of my kner: On the basis of examin and manner stated.	owledge, deat ation and/or in	th occurred at the ti	me, date and plopinion, death o	ace, and due to the courred at the time,	cause(s) ar date and p	nd manner as s ace, and due t	stated. o the cause(s	ş)	
ompl	₩	29b. Signature and title of certifier			29c. Licen	se number		29d. Date :	signed (Month,	Day, Year)		
F > F 0		Smetond	MO		D004	58631		TANUA	RY DA	200	6	
		30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type.		0001						
		TSHERING AMDO,				, RESEDA	LE, MAR	YLAN.	0212:	37		
Sta	ate	31. Date filed (Month, Day, Year)	32 Registrar's Sign		all .							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#17,perInf (351,1/18/06 TT State of Maryland 7 Department of Health and Mental Hygiene () () 00849 1 - State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Stephen L. Everist Sr January 11, 2006 7:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Timonium Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1₩ M 2□F Yrs. Director 86 Nov 5, 1919 220-09-8257 Maryland Usual Residence of Decedent unk 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ii Hygiene. other then "natural", or itema 23a or 28a-f ehow vent, the Medical Examinar must be notified at 1 ☐ Yes 2√ No Director Red Lion PA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4201 Charity Drive 17356 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: WWII 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3√ Widowed 4 □ Divorced Specify: white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 lab chemist tin mill 17. Father's Name (First, Middle, Last) Stephen Pyle Everist Stephen T. Everist 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be f and Mentel H Josephine C. Peisinger 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health at Important: If Item 27 le any injury or other tret once. Barbara Carrier/daughter 4201 Charity Drive Red Lion, PA Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ropald S. Wade State Anatomy Board 655 W. Baltimore Street Director 21201 Baltimore, MD 23a. Pint1, Enter the diserve, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failur. List only one cause on each line. Approximate Interval Between Onset and Death Immedia e Cause (Final disease or condition resulting in death) Physician CARDIOMYOPATHY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine certificate be executed physicien end s the burial-transit Due to (or as a consequence of): Physician/Medical as the attending I 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a o. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 4 MUnknown should ! 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s performed? certificete 1 Yes 2 No 1 Yes 2 No Vital Physician: After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\textbf{X} \) Other (Specify) HOSPICE Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 📉 No 2 ŏ 28a Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural death. 1 ☐ Yes 2 ☐ No Director: 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours efter To the Hospitel or within 24 hours e To the Funerel (Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of dertifier 29c. License number 29d. Date signed (Month, Day, Year) 3725 1/11/06

DHMH 17 Rev 1/2001

State Registrar TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD

8 2006

31. Date filed (Month, Day, Year)

	ą sais		For State Registrar	State of Mar	yland / [tment of H ificate of L			Reg. N	UUD	00850
	Physicia	an	1. Decedent's Name (First, Middle, Las	Jose O. Esc		C za			2. Date of D		2006 2006	3. Time of Death
	/Medic	àl	4a. Facility Name (If not institution, give		idero,		4b. City, Town, or	1 ocation of	Januar		c. County of Death	10:50 A ^M
	Examin	er	Shady Grove Adve		ital		Rockvi		Deall		Montgome	
,	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. last bii	irthday)	If Under 1 Year	If Under 2		rth		nplace (State or Foreign untry)
	Director		379-90-0010	X M 2□F	76	Yrs.	Months Days	Hours	Min. (Month, D March	5, 19	929 Per	
and	*		Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Tow	vn or Loc	ation					10d. Inside City Limits
Maryli	f eho	ō	Maryland Montgome		Gait							1 ☐ Yes 2 No
the t	. 28a-	rect	10e. Street and Number	-1 y	Garc	пстъ	10f. Zip Code			10g. C	Citizen of What Cou	untry?
h with	38 0	O ie	36 Wade Court				208	78		Ur	nited Sta	ites
deat	ar ma	Funeral Directo	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. W	as Decedent of Hi	ispanic Origi	in? (Specify Yes or N Puerto Rican, etc.)		14. Race - Amer Black, White	ican Indian,
aryiario z 1z 13-0030 should be filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: or Items 23a or 28a-f show Important: If Itam 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, Ita Medical Exactivating the notified at once.	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:					Peruvian		Specify: Whi	
72 hg	natur	Completed	15. Decedent's Ed (Specify only highest gra	ducation de completed)	16a	. Decede	int's Usual Occupa ind of work done of O NOT use retired	ation during most	of working	16b.	Kind of Business/I	ndustry
dain A	hen "	id II	Elementary/Secondary (0-12)	College (1-4or 5+)				1)	•	-		
ied v	ther ti		12 17. Father's Name (First, Middle, Last,			Sale	sman	18 Mother	's Name (First, Middle		Retail	
	ed of) Be	Jose Escudero Ga						lma Abad M			
Shout S	mark matik	은	19a. Informant's Name/Relationship (198	b. Mailing	Address (Street a		or Rural Route Numb			ip Code)
142 St	alth ar 27 le r trau		Eva Escudero / Wi	ife	3	6 Wa	de Court	, Gait	thersburg,	Mar	ryland 20	878
s ta	of Height		20a. Method of Disposition		20b. Place o	of Dispos	tion (Name of atory or other plac		Date anuary 18,	20c.	Location - City or 1	
Page	nent c int: If iry or		1 ☐ Burial 2 🖾 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State y)		•	Crematori	100	2006	Bet	hesda, M	aryland
Dallimor	Departr Importa eny inji		21. Signature of Funeral Service Licer		01305	Rob	Name and Addresert A. Pum West Mont	phrev I	Funeral Home	/Roc	kville, In	c. nd 20850-2805
9	7		23a. Part1. Ever the disease, or com shock, or heart failure. List only	plications that caused th	e death. Do						ratylai	Approximate Interval Between
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/!	Medical		resulting in death)	Due to (or as a d								
Ex	caminer		Sequentially list conditions,	b. Pneumon								
V 78	sit	Examiner	cause. Enter Underlying Cause (Disease or injury	Die to (or as a c	ionsaquence	FOI):						
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death certificate be executed	been signed by the attending phe should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetel death		Ectopic pregnancy Other (specify)				23d. Date of deli Month	very Day Year
r in	d by t letach	Phy	9 ☐ Unknown Part II. Other significant conditions of		not resulting	in the un	tacking across sur	en in Dort I	220 Did	tobacco	a usa aastributa ta	the cause of death?
Ords, 7.0	signe 1 be d	by	Advanced Idiopath	-	_							bably 4 Unknown
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1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ficate r, pag		Dysfunction							ormed?	No 1 ☐ Yes	2 No
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9 y	er this	H-	27. Manner of Death	28a. Date of Injury (Month, Day)		Time of	28c. Injun	y at	28d. Describe			ny)
di j	ath. r: Aft ie fun	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio		ear)	Injury		Yes 2 □ N	10			
UIVISION I or Attending	s after death. I Director: After t d in by the funera	Certification:	3 Suicide 6 Could not be determined	e 28e. Place of Injury building, etc.	- At home, f (Specify)	farm, stre	et, factory, office		28f. Location City or To	(Street a	and Number or Ru	ral Route Number,
2 8	irs aft ral Di led in			3.								
Hosp	within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edicai	29a. Certifier 1 ← Certifying Ph (Check only one) 2 ☐ Medical Example (Check only one)	nysician: To the best of miner: On the basis of e and manner state	xamination a	ge, death ind/or inv	occurred at the tin estigation, in my o	ne, date and pinion, deat!	d place, and due to the h occurred at the time	e cause , date a	(s) and manner as ind place, and due	stated. to the cause(s)
o the	o the	Med	not Circuture on the of cofficer	^	1		29c. Licens	e number		29d. D	Date signed (Month	o, Day, Year)
	3⊢ŏ		· K. My	ansure	Ian		D533	67		Jan	nuary 16,	2006
	1		30. Name and address of person who	completed cause of dea	th (Item 23a)) (Type, F				- 41.	· · · · ·	
	9			,				105,	Olney, Ma	ry1a	ind 20832	
A.e.	Sta		31. Date filed (Month, Day, Year)	32. Registrar	s Signature							
12	Regist	200	Rajan Shyamsundar 31. Date filed (Month, Pay, Year) JAN 18	2006 policeras	B	A STATE OF THE PARTY OF THE PAR	and s					
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** January 5:49 p M Charlotte Susan Franz 13, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore Glen Meadows Care Center Glen Arm | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb. | 24,1920 5. Social Security Number (6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F Yrs. Director 85 Maryland Usual Residence of Decedent with the Maryland 10h County 10c. City. Town or Location 10a. State 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified at Maryland Baltimore Glen Arm 1 ☐ Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 21057 USA itams 23a 11630 Arm Road #G06 Glen Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐ No Specify: White þ Specify 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Recestered Nurse Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mildred Archie Barkdoll Neadv ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: if Item 27 to any injury or other trau John H. Franz, Jr. / SOn P.O. Box 229 Glen Arm, Md. 21057 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location · City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hilltop Service Corp. 1/17/06 4 Donation Towson, Maryland of Funeral Service Licensee 22. Name and Address of Facility 21. Signatu 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ONGESTIVE **Physician** 1 werk disease or condition resulting in death) /Medical Due to (or as a consequence of): CARDIO MYOPATHY Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Box 68760. to the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and does detached for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Day Month 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 No Division of Vital Records, P.O. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 SNo Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Teath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funeral L 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) KAMANAGOPALANMO 21220 ROLLING GROSS RUANS GOPA 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JAN 1 8 2006 Consta Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rag. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2105 pm January 16 2006 Violet E. Feltman /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Battmore

Hunder 1 Year If Under 24 Hrs. 8. Date of Birth
(Month Day), Year 1922

Dec. 25, 1922 St. Agnes HOSPITAL Birthplace (State or Foreign
 Suntry) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 25 F Yrs. Director 83 217-16-6348 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow other traumatic event, the Medical Examiner must be notified at ¥¥ Yes 2 □ No Director MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or USA 1533 Furnace Ave. 21060 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. "naturel", or Items 11. Marital Status hours after 1 Never Married 2 Married Maryland 21215-0036 white white 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 K Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) Coflege (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filt.
Department of Health and Mental Hy
Important: If Item 27 is marked oth
any njury or other traumatic event Henry W. Schultz Minnie Wiesenmiller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 1533 Furnace Ave. Glen Burnie, MD 21060 James E. Feltman - son Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Baltimore City Loudon Park 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura 1 Funeral Service Lice see 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, MD 21229 23a. Part / Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus on each the. Approximate Interval Between Onser and Datif fmmediate Cause (Final disease or condition resulting in death) Pnysician /Medical Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine use as the burial-transit and 68760 tha attending physician Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 2 Fetaf death in the past 12 months? Year jo Month Day 4☐ Pregnant at time of death 5 Other (specify) this certificate has been signed by the an director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ Records, 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 2 100 1 ☐ Yes Viital 25. Was case referred to medical Be 26. Place of Death | Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 No 1 Dispatient Medical Certification: To 2 ER/Outpatient 3 DOA ŏ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner ath 28d. Describe how injury occurred Injury Division 1 Chatural 5 Pending 1 Yes 2 No death. investigation 2 Accident within 24 hours after death To the Funeral Director: , completely filled in by the f 6 Could not be 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide ŏ Hospital 1 Decritying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 12006 20000 16 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

4

00 Calm

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2006 2110 January <u>Charles Joseph Foley. Jr.</u> /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Havre de Grace Under 1 Year | If Under 24 Hrs Harford Harford Memorial Hospital Security Number 7. Age (In yrs. last birthday) If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) 12/15/1927 Birthplace (State or Foreign Country) **Funeral** Months Hours Min 1 X M 2 □ F Yrs Maryland Director 219-28-4431 78 Usual Residence of Decedent filed within 72 hours atter deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours atter deeth with the Maryla Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Itema 23e or 28a-1 ehow any Injury or other traumatic event, "In Madical Examinar must be coulded an once. 1 Yes 2 □ No Director Havre de Grace MD Harford 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21078 400 South Union Avenue USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Yes 2 No If Yes, Give Year or Dates: 1946-48 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed Doctor years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mildred Heisler Charles J. Foley, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Neta G. Foley- Wife 400 S. Union Avenue. Havre de Grace. MD 21078 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.A. Ferris & Co. 01/17/06 West Chester, PA 21. Signature of Funeral Service Licensee and Addrass of Equility Ll-Smith Funeral Home, P.A. <u>Washington, Havre de Grace,</u> MD 21078 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Box 68760. use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ğ Day Year 5 Other (specify) P.O. P the (page 2 should be detached 9 Unknown ģ Part II. Other significant conditions contributing to death but for resulting in the underlying cause en in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 Yes 2□ No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one Certification: To 1 Yes 2 No 1 🗌 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 R/Outpatient 3 DOA 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 1 A Natural 2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending s efter death. 1 Yes 2 No investigation the 3 Suicide 6 Could not be determined in by 1 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours of To the Funerel pelli Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier completely (Check only one) To the 29b. Signature and title of 29c. License number 29d. Date signed (Month, Dev. Year) 30. Name and address of pr use of death (Item 23a) (Type, Print) Day, Year) 32? Registrar's Signature State 8

DHMH 17 Rev 1/2001

Registrar

		1 - State Registrar		epartment of Health and N Dertificate of Death	Reg. No	1000 0000	
Physic /Medi		1. Decedent's Name (First, Middle, Last) Babette Fulton			2. Date of Death Month Da January 8	1.4	
Exami		4a. Fecility Name (If not institution, give str 5600 Roxbury Place		4b. City, Town, or Location of Death Baltimore		. County of Deeth	
Funeral Director		0/6-26-8306	7. Age (In yrs. last birth	Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Aug 7, 193		
laryland ahow	25	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location timore		10d. Inside City Limits 1 ☑ Yes 2 ☐ No	
with the N a or 28a-f	Direct	MD 10e. Street and Number 5600 Roxbury Plac		10f. Zip Code 21209	10g. Ci	tizen of What Country?	
13-0030 172 hours after death with the Marylar "natural", or Itams 23a or 28a-1 ahow idical Examiner must be notified at	by Funeral Director	•	2. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ▼No If Yes, Give	13. Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- b Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: white	
IIIU X I X I 3-0030 be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Itams 23a or 28a-1 ahow event, it is Medical Exemina must be notified at	Completed b	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	completed) ((lecedent's Usual Occupation Give kind of work done during most of won ife. DO NOT use retired)	king unk 16b. k	Kind of Business/Industry unk	
	0	17. Father's Name (First, Middle, Last) Kurt Pilzer	e Kraus				
and aalt n 2 er 1		Judith P. Fulton/da 20a. Method of Disposition	aughter 190	Mailing Address (Street and Number or Rull) 3 Indian Head Road Disposition (Name of	Baltimore,		
DAILLIMOTE Dermit. Pages 1. Department of He mportent: If Iten in y Injury or oth page.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ROPALO S	moval from State	crematory or other place)			
D Per Per Per Per Per Per Per Per Per Per		1 man 1/10	Me	22. Name and Address of Facility State Anatomy Board Baltimore, MD 2120 It enter the mode of dying, such as cardiac	1	Approximate	
Physician /Medical		sh. For heart failure. List only one Immediete Cause (Final disease or condition resulting in death)	Ovarian Due to (or as a consequence of	carce		Interval Between Onset and Death	
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S, F.O. BOX OB/OU, es that the death certificate be executed igned by the attending physicien and be detached for use as the buriat-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		23d. Date of delivery Month Day Year			
Hecords, P.O. The law requires that the tee has been signed by the page 2 should be detached.	b	Part II. Other significant conditions cont	ributing to death but not resulting in t	the underlying cause given in Part I.		use contribute to the cause of death?	
	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No	
on of Vital I ding Phystcian: Th h. After this certificate funeral director, pag	tion; To Be	27. Manner of Death	ospital: 1 Inpatient 2 ER/Outp 28a. Date of Injury (Month, Day Year) A	patient 3 DOA Other: 4 Nursing H	th (Check only one) ome 9 Residence 28d. Describe how inju	6 □Other (Specify) Iny occurred	
or Attan fler deat director: n by the	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farr building, etc. (Specify)		28f. Location (Street a City or Town, Stat	nd Number or Rural Route Number, (e)	
To the Hospitel within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier (Check only one) Certifying Physical Exemination	icien: To the best of my knowledge, er: On the basis of examination and and manner stated.	death occurred at the time, date and place for investigation, in my opinion, death occu	, and due to the cause(s rred at the time, date ar	i) and manner as stated. id place, and due to the cause(s)	
To the within To the comp	W	29b. Signature and title of certifier M. Neu	anon MiD	D 2 7904		ate signed (Month, Day, Year)	
		30. Name and address of person who cor	npleted cause of death (Item 23a) (TN, M.O. 10755	Type, Print) FALLS RD # 200	LUTHER	VILLE MO 21093	
S Regis	tate trar	31. Date filed (Month, Day, Year) JAN 1 8 2006	3. Registrar's Signature	Carle			

State of Maryland / Department of Health and Mental Hygiene () For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Daniel F. Fragnul January 10, 2006 1:42 P. M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery 8. Date of Birth (Month, Day, Y. Nov. 19, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 X M 2 ☐ F 1922 Italy 072-30-5630 83 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or iteme 23a or 28a-f show the Medical Examiner must be notified at Maryland Montgomery Bethesda 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4400 East West Highway Apt. #925 20814 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours efter 1 ☐ Yes 2 [XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygie important: if item 27 is marked other it any injury or other traumatic event, the once. Physiatrist Medicine 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Doria <u>Natale Fragnul</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita Fragnul/Wife 4400 East West Highway Apt. #925, Bethesda, MD. 20814 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Gate of Heaven January 17, Silver Spring, Maryland 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 StOther (Specify) Entombment 22. Name and Address of Facility Robert A. Pumpliney Funeral Home/Bethesda-Chevy Chase, Inc. 755/ Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licensee Malela M01353 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atheroscherotic Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 X No 3 Probably 4 □Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one examiner? Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2 No 2 ER/Outpatient 3 DOA Certification; To 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide within 24 hours after To the Funerei Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 39 Name and address of person who completed cause of death (Item 23a) (Type, Print) loims atricia 31. Date liled (Month, Day, Year) 32 Registrar's Signature Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [00856 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle Last) 3. Time of Death Year **Physician** David 105hva 2006 0556 AM Matthew 14 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Conever Columbia Country HOSP tan Howard 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Sex 1 M M 2 □ F **Funeral** Days Hours Yrs Director none January 10, 2006 Usual Residence of Decedent Maryland with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Hygiene. other than "natural", or items 23a or 28e-f show out, tra Mozical Exactrost must be notified at 1 Yes 2 No Director Maryland Anne Arundel Ft. Meade 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other then "" any injury or other traument". 7907 B Reed Court 20755 Funeral U.S.A Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□Yes 2No Specify: δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) never worked n/a never worked 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle Last) Be ပ William C. Foster Kimberly R. Feuehardt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7907 B Reed Court Ft. Meade. Maryland 20755. Mr. William Foster Eather, 20a. Method of Disposition
1. Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) 01/17/2006 Clarksville, Maryland Columbia Memorial Park
22. Name and Address of Facility Slack Funeral Home, P.A 23a. Part 1. Soler the disease, or complications that caused the death. Do not enter the mode of dying, such as caldiac or respiratory affect, MD 21043 shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** extreem Rematority disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Du to (or as a consequence of): Examiner or Attending Physician: The law requires thet the death certificate be executed Momin resulting in death) Last Due to (or as a consequence Box 68760 Physician/Medical elsis IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown been signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 3 Probably 4 Unknown 2 X No Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No hes 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 XNo 1 Alnpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Aftert 1 Natural Injury 5 Pending To the Hospics within 24 hours effected, To the Funerel Director: All 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ADB

SSE

32. Registrar's Signature

MD

D30

	1	For State Registrar		State	of Marylan	-	artmen rtificat			and M		giene Reg No.)6 (00857
Physician	n	1. Decedent's Name (F									2. Date of Dea	15/200	Year	3. Time of Death 11:25PM
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Funeral		5. Social Security Numb	ber 6. S	Sex	7. Age (In yrs.	last birthday)	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Birt	h V Vearl	9. Birthp	place (State or Foreign
Director		577-44-424	12	M 2□F	70	Yrs.	MOTITIS	Days	Hours	MIII.	8. Date of Birt (Month, Day 7 / 15 / 1	935	Wash	ington, DC
and	-	Usual Residence of De 10a. State 10	ocedent Ob. County		10c. Cit	ty, Town or Lo	cation					-	1	0d. Inside City Limits
Maryli f sho	0		Worcest	tor		Berlin								1 🗆 Yes 2 🕱 No
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and and lealth m 27 her tr		Barbara G		Wife	loo.						in, MD			
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calling	-	`4 □Donation 5 [Hu	ntt Cr						Waldo		
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after after din b	Certification:	4 Homicide	determined	build	ding, etc. (Speci	fy)	001, 120101,	,			City or Tox	m. State)		
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State	e	31. Date filed (Month,	Day, Year)	32.	Registrar's Signa	ature /	8	2	7 ~	1-16	7	150	16/2	,
Registra		JA	N182	006	College .	K A	mile	,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 105 0 5 6

		•	For State Registrar	Glate of Maryla	-	rtificate of		Reg.		00000
	Dhysisi		1. Decedent's Name (First, Middle, La					2. Date of Death Month	Day Yeer	3. Time of Death
	Physici: /Medic		Grace Dixon Gran	nt				_	11, 2006	930 A M
	Examin	er	4a. Facility Name (If not institution, gi			Location of Death	4c. County of Death			
			2416 Gaither Stre		- last birth de	Temple H:			Prince Ge	
	Funeral Director			Sex 7. Age (In yrs 1□ M 252F 78	s. last birthday Yrs.	Months Days	Hours Min.	8. Date of Birth I (Month, Day, Ye December	20, Cott	hplace (State or Foreign untry) On, Alabama
	/land		10a. State 10b. County	10c. C	City, Town or L	ocation				10d. Inside City Limits
	Many Ff sh	tor	Maryland Prince (George Te	mple H	ills				1⊕Yes 2□No
	h the or 28s	irec	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	untry?
	23a c	Funerai Director	2416 Gaither Stre	eet		207	48	Un	ited Stat	es
	r dea	ne	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatih and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itams 23a or 26a-f show any injury or other traumatic event, the Modical Examinational be notified at once.	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ঐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ₹ TXNO	Specify:			lack
15	"nati	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Deci	edent's Usual Occup s kind of work done o DO NOT use retired	ation during most of worki	na l	. Kind of Business/I	
12	withii ene. than	E C	Elementary/Secondary (0-12) Twelve	College (1-4or 5+) One	1 _	odial Sur		1.	airíax Co Schools	unty Public
d 2	filed Hygi other	e Cc	17. Father's Name (First, Middle, Las.		Lus	OGLAL DU		(First, Middle, Maid		
<u>a</u>	ild be lental ked ic ev	To B	Thornton Dixon				Lola Will	liams		
ary	shou and M a mar umat	_	19a. Informant's Name/Relationship	Type, Print)	/19b. Mail	ing Address (Street	and Number or Rura	I Route Number, Ci	ty or Town, State, Z	Tip Code)
Σ	alth alth a 27 is		Charles Grant /S	on	243	6 Gaither	Street 7	Cemple Hi	lls MD 20	748
ore	es 1 a of He fitem r oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [Place of Disp cemetery, cre	osition (Name of matory or other place	a) Janua	ry 14,	. Location - City or	Town, State
Ĕ	Pag ment ant: i		'4 □Donation 5 □Other (Speci	fy) Ha		Memorial :	Park 2006	La	ndover Ma	ryland
Baltimore,	Depart Depart Import any inj		21. Signature of Funeral Service Lice	gsee /				ert G. Ma	son Funer	al Home Inc
	₹0 E € 0	10	Dand	· day		661 Good 1				0020
}	Physician /Medical Examiner		23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	aDue to (or as a conse	ephon	va de	g, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a corise	equence of):					
1	ertificate be executed ing physician and e as the burial-transit	Examiner	that initiated events	с.						
68760,	oe execian a		resulting in death) Last	Due to (or as a conse	equence of):					
87	cate b	Medical		d						
Box 6	eath certifi attending for use as	-	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe		□Ectopic pregnancy			23d. Date of deli	very
o.	0 0	hysician	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of 9☐ Unknown		Other (specify)			Month	Day Year
S, P	requires that the een signed by th nould be detache	by P	Part II. Other significant conditions	contributing to death but not re	sulting in the	underlying cause give	en in Part I.	23e. Did tobac	co use contribute to	the cause of death?
ord	v require been sig should b							1 🗆 Yes	2 □ No 3 □ Pro	obably 4 Munknown
Vital Record	e law has b	ompleted					-	24a. Was an autopsy performed	prior to death?	topsy findings available completion of cause of
ita	Physician: Th this certificate ral director, pag	BeC	25. Was case referred to medical examiner?				26. Place of Death	9	3.30	
of V	S O	မ	1 □ Yes 2 ZNo		☐ ER/Outpatie		4 Nuising Hor	me 5 Residence	e 6 □Other (Spec	sify)
no On	ding F	ioi	27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury	Worl		28d. Describe how i	nju ry occurred	
Division	i or Attending after death. Director: After in by the fune	icat	2 Accident investigation 3 Suicide 6 Could not l	09 Place of Injury - At	home form o		Yes 2 □ No	28f. Location (Stree	and Number of Ou	and Day of the second
Ω	after Dire	Certification:	4 Homicide determined	building, etc. (Spec	cify)	reet, lactory, office		City or Town, S	tate)	rai noute ivaniber,
	Hospital 24 hours a Funeral C		29a. Certifier Certifying P	hysician: To the best of my kr	nowledge, dea	th occurred at the tin	ne, date and place, a	and due to the cause	e(s) and manner as	stated.
	To the Hospital or Attanding Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only 2 Medical Exa	miner: On the basis of examinand manner stated.	nation and/or i	nvestigation, in my o	pinion, death occurre	ed at the time, date	and place, and due	to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier			29c License	e number	29d.	Date signed (Month	n, Day, Year)
3	/					0/	793		1/16/06	
	13		30. Name and address of person who	completed cause of death (Ite	em 23a) (Type	Print) As 1	108 F	7. WASh	ugher	My 2mac
Ì	Sta Registr		31. Date filed (Month, Day, Year) JAN 1 8 20	34. Registrar's Sign	nature	Will I			1	· · · · · · · · · · · · · · · · · · ·

			1 - For State Registrar	State of Mar		epartme Certifica			and M		iene	006	00859
			Decedent's Name (First, Middle, Last	t)						2. Date of Deat	h		3. Time of Death
	Physici		Margaret L. Grub	hs						Month O1	O8	2006	05:00aM
1	/Medic Examin		4a. Facility Name (If not institution, give			4b. City	, Town, or	Location o	f Death		T	County of Deat	
	LAGITIII	C1	Arcola Health an			S	llver	Spri	ng			Montgo	omerv
	Funeral		Social Security Number 6. S		In yrs. last birtho	fay) If Unde	r 1 Year	If Under	24 Hrs.	8. Date of Birth		9. Birt	hplace (State or Foreign
	Director		484-56-9660	□м 2 <u>/Д</u> уЕ	98 Yr	Months.	Days	Hours	Min.	(Month, Day, 05-03-			ownery)
	D		Usuat Residence of Decedent								201		
	how		10a. State 10b. County	1	Oc. City, Town o								10d. Inside City Limits
	a-f	cto	MD Montg	omery	Silve	er Spri	ng						1 ☐ Yes 2√CtNo
	다 다 0r 26	Director	10e. Street and Number			10f. Z	p Code			11	0g. Citiz	en of What Co	untry?
	23a	al	302 Springloch E	Rd.				2	0904		U	SA	
	dea and and and and and and and and and an	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Dec	edent of Hi	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	1	4. Race - Ame Black, White	
9	or it	Ŧ.	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 ☐ No If Yes, Give		1 ☐ Yes		Specify:					nite
ğ	ural'.	d by	3 XWidowed 4 ☐ Divorced	Year or Dates:									
ζ.	72 nat	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	((ecedent's Us live kind of w	ork done d	lurina most	of worki	ng	16b. Kin	d of Business/	Industry
2	hen of	m d	Elementary/Secondary (0-12)	College (1-4or 5+)		_{fe. DO NOT} omemake		,				Own Hon	
7	filed within 72 hours after death with the Maryland Hygiene. the than Instural, or Items 23a or 28a-f ahow ant, the Madical Examble frontilled at	ပိ	17. Father's Name (First, Middle, Last)		110	лиешак	ST.	10 Mothe	da Nama	(First, Middle, A			e
JUE	tall H	Be	John David Lehma	m						Elizabe			1
Maryland 21215-0036	d Mei d Mei nark	၉			105.1	Lattina Adda	(0)			I Route Number,			
ā	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Deperment of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itema 23a or 28a-f ahow amy injury or other traumatic avant, the Marical Example mental be notified at an angle.		19a. Informant's Name/Relationship (1 Margaret Ryan/da							lver Spi			
o O	Healt mm 2 ther		20a. Method of Disposition		20b. Place of D			T		-		ation - City or	
و	in the		1 ☐ Burial 2 ☐ Cremation 3 ☐		cemetery,	crematory or	other place					ltsvil]	
≣	rtant rtant		4 Donation 5 Other (Specify		cnesal					2-2006	ъе	TESATI	re mu
Baltimore,	Dependence of the population o		21. Signature of Funeral Service Licen	7	200	22. Name a	Fun	eral	& Cr	emation	Ser	vice	
			23a. Part1. Enter the disease, or comp	2 mois						r Spring		20910	Approximate
			shock, or heart failure. List only	one cause on each line.	o doath. Do no	eriter trie tric	de or ayırıç	y, such as	cardiac	i lespiratory arre	351,		Interval Between Onset and Death
)6 I	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Myocard:			1						Sudden
	/Medical Examiner		f	Due to (or as a d									
		<u>-</u>	Sequentially list conditions,	b. Chronic Due to (or as a c			ulmo	nary	Dise	ase			
	ed set	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D00 t0 (01 a3 a 0	onsequence or,								
	and and	xar	that initiated events resulting in death) Last	C. Due to (or as a c	onsequence of)	:							
8760,	The law requires that the death certificate be executed ate hes been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	alE											
687	phys the	dical		d									
	that the death certific ed by the ettending p detached for use as	Physician/Me	IF FEMALE:	23c. If yes, outcome of	pregnancy							3d. Date of deli	
Вох	eath etter for L	clar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at tin	Fetal death	3 ☐Ectopic p 5 ☐ Other (s						Month Month	Day Year
o.	the d y the ched	iys	1 ☐ Yes 2000No 9 ☐ Unknown	9□ Unknown		- L	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
۵.	that led b	P	Part II. Other significant conditions of	ontributing to death but i	not resulting in th	ne underlying	cause give	n in Part I.		23e. Did tob	acco us	e contribute to	the cause of death?
Vital Records,	uires I signe Id be	d by	Hypertension							1 🗆 Ye	s 2 / Z	No 3□Pr	obabiy 4 Unknown
Ö	w requir been si should	lete	The state of the s							24a. Was a		Odb Moro ou	tongs findings as a lebto
ě	he lay	Completed								autops	y	prior to death?	topsy findings available completion of cause of
æ		ပို	Of Manager of the state of the								2√No	1 ☐ Yes	2 No
5	ysician: The I is certificete he director, page	00	25. Was case referred to medical examiner? 1 Yes 2 XNo	Hospital:	- C 50/0		Othe	r		(Check only on			
ō	Phys r this ral di	. To	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 Inpatient			UA	4X PINU		ne 5 Reside			cify)
0	ding h. Afte fune	tlor	1 ⊈Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Y	<i>'ear)</i> Inju		28c. Injury Work	(? /es 2 ∐ f			,,		
Division of	Attending Physician: r death. ector: After this certific by the funeral director,	flca	3 ☐ Suicide 6 ☐ Could not be		- At home, farm	. street. facto				28f. Location (St	reet and	Number or Ru	ıral Route Number,
Š	after Dire	Certification:	4 Homicide determined	building, etc.	(Specify)	,,,	,,			City or Town	, State)		
_	To the Hospital or Attanding Phys within 24 hours after death. To the 24 hours after this: completely filled in by the tuneral dis		29a. Certifier 1 Certifying Ph	ysician: To the best of I	my knowledge o	leath occurre	at the tim	e, date an	d place. a	and due to the ca	ause(s)	and manner as	stated.
	a Ho a Fui letely	Medical	(Check only 2 Medical Examone)	niner: On the basis of ex and manner state	camination and/o	or investigation	n, in my op	oinion, dea	th occurr	ed at the time, da	ate and	place, and due	to the cause(s)
	To the comp	Me	29b. Signature and title of certifier			25	c. License	number		25	9d. Date	signed (Monti	h, Day, Year)
	1		1				DO	05352	8		01-	11-2006	5
1	1		30. Name and address of person who	completed cause of dea	th (Item 23a) (To	rpe, Print)							
	0				ield Rd		on M	D 209	02				
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	20 .	-						
	Registr		JAN 1 8 2006	Barren A	A CONTRACT	A STATE OF THE STA							

State of Maryland / Department of Health and Mental Hygiene 00860 For State Registra Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Jan. 8, 2006 **Physician** 8:05 p M Margaret Ruth Gorsage /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Bethesda 8709 Cranbrook Court | Hunder 1 Year | Hunder 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 8/15/21 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Country)
Indiana 1 🗌 M 2X X 84 Yrs. 311-14-0386 Director Usual Residence of Decedent 10d. Inside City Limits deeth with the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Heelth and Mental Hygiene.
Important: If item 27 is marked other than "natural", or iteme 23a or 28a-f ehow any injury or other traumatic event, it a Mydical Examinat must be notified as once. 10a. State 10b. County 1 Yes 2 □ No Bethesda Montgomery Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20817 8709 Cranbrook Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 → O Specify: white Specify Baltimore, Maryland 21215-0036 þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Finance Bookkeeper 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ada Gertrude Hopkins Thomas Warren John ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8709 Cranbrook Court, Bethesda, MD Michael Gorsage, son 20c. Location - City or Town, State 20b. Place of Disposition /Name of 20a. Method of Disposition Chesapeake Crematory 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/10/06 Beltsville, MD Rapp Funeral and Cremation Services 933 Gist Avenue Silver Spring, MD M00382 Tiple & Lohumann 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 4 months disease or condition resulting in death) Metastatic Carcinoma - liver /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ettending physicien cai the Physiclan/Medl IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ed by the 9 Unknown 9 Unknown s been signed by to should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate has page 2 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours effer death.

To the Funerel Director: After this certifice 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5XX esidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 2 No 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 1 XNatural 5 Pending investigation 1 TYes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0030484 January 9, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wisconsin Avenue, Chevy Chase, MD 10801 Unosella Dr. Charles 32. Registrar's Signature 31. Date filed (Month, Day, Year) Space n State

DHMH 17 Rev 1/2001

Registrar

536

	1	For State Registrar	5	State	of Ma	ırylanı		artmen <i>rtificat</i>				lental Hy	giene Reg. No	, 000)	008	61
Physician		1. Decedent's Name (First, Mide Earle Joseph		n								2. Date of De Month	eath 08	y 2006	ear	3. Time (
/Medica Examine		4a. Facility Name (If not institution Holy Cross Ho			um <i>ber)</i>					Location Spr:			1	. County of		1	
Funeral Director		5. Social Security Number 014-22-8431	6. Sex 1X M	1 2 F	7. Age	76	ast birthday, Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bii (Month, Da	rth ay, Year)	9	. Birthp	lace (State try) sachu:	or Foreign
ehow		Usual Residence of Decedent 10a. State 10b. Count MD Mon	•			_	, Town or L									0d. Inside (City Limits
sa or 28a-f ell be ralling		10e. Street and Number 1115 Dunoon R	tgome	гу		- 5:	ilver	10f. Zip	Code	2090:	3		-	tizen of Wha	at Coun		s 2 No
permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or items 23e or 28e-f ehow important: if item 27 is marked other then "naturel", or items 23e or 28e-f ehow endy injury or other traumatic event, the Medical Exeminar must be rigillised at once.	2	11. Marital Status 1 Never Married 20xMa 3 Widowed 4 Divorce	rried	Was Dec Armed F 12 4 es If Yes, G Year or	orces? 2 □ N Sive		S. 13.	Was Deced If Yes, specification		spanic Or n, Mexical Specify:		ecify Yes or No Rican, etc.)	0-	14. Race - Black, Specify:	Americ White, 6	etc.	
ed within 72 houygiene. Ner then "nature" t, the Medical E	out bleve	15. Decede (Specify only high Elementary/Secondary (0-12)	nt's Educat est grade d	tion completed College 5+		+)	(Give life.	dent's Usua kind of wo DO NOT u	rk done d se retired,	uring mos				ind of Busin		,	
Mental Hy arked oth	ב	17. Father's Name (First, Middle Abraham Gerso	•							_		(First, Middle sterman		Sumame)			
end 2 sho saith and I n 27 is me er traume		19a. Informant's Name/Relation Lieta Gerson/		, Print)								Route Numb				Code)	
Pages 1 of He ant: If item		20a. Method of Disposition 1 □ Burial 25□ Cremation 4 □ Donation 5 □ Other (noval from	n State	Cé	ace of Disponentery, cre	matory or o	ther place			Pate .7-2006		ocation - Cit :1tsvi			
permit. Departi importa eny inju		21. Signature of Funeral Service	o Licensee	en	A	1003	82 2	2. Name ar Rapp 933	Fun	eral	& Cr	ematio r Spri	n Se	rvice D 209	10		
Cate be executed Wedical Examiner Sthe burian-fransit	dical Evaluated	23a. Part1. Enter the disease, shock, or heert failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	Coro	onar o (or as a erte o (or as a	y Art a consequ nsion	tery Duence of): n and mence of): llitus	iseas	е	, 33311 43		, тозрінакогу а				Approxima Interval Be Onset and	etween
thet the death certific ted by the ettending f detached for use as	yalcıdı vind	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	230		birth gnant at	of pregnal 2 Fetel time of de	death 3	⊒Ectopic pr ⊒ Other (sp						23d. Date o Month		ry Day	Year
quires thet an signed b uid be deta	2	Part II. Other significant condit Atrial Fibril	ions contri latio	buting to	death bu	it not resu	alting in the u	inderlying c	ause give	n in Part I			tobacco Yes 2	use contribu	ite lo th ∐Proba		death?
hysiclan: The law requirence of the law requirence on this certificate has been so I director, page 2 should be Commisted.) .	25. Was case referred to medic										1 Yes	psy ormed? 257No	dea	re autop r to con th? Yes	esy findings	available cause of
tter a	2	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pend 2 Accident inves 3 Suicide 6 Coul	Hos ing tigation	28a. Date (Mo.	onth, Day	Year)	ER/Outpatier 28b. Time of Injury	f 2	8c. Injury Work 1 🗆 Y	r: 4□NL	ursing Hon	ne 5 Resi	idence how inju	ry occurred			mber,
To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the tu		29a. Certifier t☐ Certify (Check only 2 Medica	ing Physic					h occurred	at the tim	e, date ar	nd place, a	and due to the		•	er as sta	ated.	· · · · · · · · · · · · · · · · · · ·
To the within 2. To the complete		29b. Signature and title of certif		and ma	nner sta	ted.)		. License	number		od at the time,	29d. Da	te signed (A	Aonth, E		5)
H K		30. Name and address of person Karen L. Jero						,		1341 MD 2	20910)	01	-10-2	006		
State Registra		31. Date filed (Month, Day, Yea JAN 1 8 20	r)				ture		8								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month 9:12 PM M Lawrence Grossman January 13, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Gilchrist Center for Hospice Care Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/23/1924 Birthplace (State or Foreign Country) **Funeral** Months Days Min. 1-3M 2 F 81 Hours 103-14-3976 NY Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or itema 23a or 28a-f ehow or other traumatic event, the Mudical Examinar must be notified at MD 1. Yes 2 □ No Baltimore City Baltimore Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5828 Pimlico Road 21209 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1787es 2 □ No If Yes, Give Year or Dates: WWIII 1 Never Married 2 Married 1 Yes 2 No Specify White Specify: þ 3 ☐ Widowed 4 ☐ Divorced "natural" Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Higher Education al Hygiene. College (1-4or 5+) 5+ Elementary/Secondary (0-12) Biochemist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health end Mental H lant: If Item 27 is marked ott Isadore Harry Grossman Anna Lipkin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Barbara Grossman/Wife 5828 Pimlico Road Baltimore, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Jan 17 20c. Location - City or Town, State 1 ☐ Burial 2- Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Beltsville, Maryland Chesapeake Crematory 2006 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) AITUSMEC **Physician** ENDSTAGE rB /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physicien end s the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Completed by Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ibrillation 3 Probably 1 ☐ Yes 2 ☐ No 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 No 1 Yes Division of Vital 25. Was case referred to medical examiner?

Yes 2□ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE ို 1 Inpatient 2 ER/Outpatient 3 DOA Š After this funeral c 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 27. Mapner of Death 28b. Time of 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a
To the Funeral C
completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) endall 2006 person who completed cause of death (Item 23a) (Type, Print) N. Charles Street/Bulto MD 1000 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2006 Registrar

ORIGINAL

orossman,

Box 68760,

P.O.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year F. Mary Gaudreau January 17, 2006 3:40 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospice of Baltimore-Gilchrist Center Towson Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 □ M 2 🛛 F Director 479-34-0342 Feb. 74 14,1931 I owa Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County or then "natural, or items 23s or 28s-f ehow the Medical Examinar must be notified at 10d. Inside City Limits 1 Yes 2 No Director Maryland Baltimore Towson 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 2025 Skyline Road 21204 death U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours efter 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry e filed within 7 al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be : 1 and 2 should be fi Heelth and Mental F tem 27 is marked ot ပ Andrew С. Kellv Norma Brennan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2 a Depertment of Heelth ar Importent: If item 27 is any injury or other trau 2025 Skyline Road <u>William L. Gaudreau</u> Husband Towson, Maryland 21204 20b. Place of Disposition (Name of Commetery, crematory or other place)
Dulaney Valley 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 □Donation 5 □ Other (Specify) Memorial Gardens 1-21-2006 Timonium MAry land 21. Signature of Furnity Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 Co 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Aeri weeks /Medical Due to (or as a consequence of): Examiner homic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Division of Vital Records, P.O. Box 68760, Ts or of Attending Physicien: The law requires that the death certificate be executed attending physicien end for use es the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day 4☐Pregnant at time of death 5 Other (specify) ned by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cete hes been signated bage 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No this certificate 1 Yes 2 No Hospitei or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After Injury 5 Pending investigation 1 Naturat death. 1 ☐ Yes 2 ☐ No 2 Accident the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funerel (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) un) 25200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V. Charlest. Batto, Md 2,208 5/4C 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2006 8 Registrar

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Maryland

Baltimore,

greak

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year James Michael Godzik 11:30P M JANUARY 16,2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center Baltimore Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | O2/08/1947 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□ F 58 219-44-5683 MD Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits "netural", or iteme 23a or 28a-f ehow the Medical Exeminer must be notified at MD 1 ☐ Yes 2 ZÍNo Baltimore Towson Funeral Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 904 Shelley Road 21286 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 1 □Yes 2 □ No
If Yes, Give
Year or Dates: 1963-1966 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: White 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Westinghouse than College (1-4or 5+) Elementary/Secondary (0-12) Manager other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be fill ment of Heelth and Mental Historical fillem 27 is marked of James Martin Godzik Mabel Virginia Bafford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Heelth ar Important: if item 27 is any injury or other trau Mary Ellen Isennock/Sister 904 Shelley Road Towson, MD 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Jan 19 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Beltsville, Maryland Chesapeake Crematory Inc. 2006 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Cremation and Funeral Alternatives 23a. Part1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 8717 Green Fastures Drive Baltimore, Maryland 21286-Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PNEUMONIA 8 DAYS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ettending physicien and for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 (No 1 🗆 Yes 3 ☐ Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 No certificete 1 ☐ Yes Director: After this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 Inpatient Other: 1 Yes 2 XNO 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital o within 24 hours eft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D 0018662 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM H. GOLDINER M. D. 7601 DSLER DRIVE TOWSON MARYLAND 21204
31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® 115 00865 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** ${\tt A}^{\,{\sf M}}$ BETTY PHYLLIS January 14. 2006 1:40 GEISBERT /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Frederick Memorial Hospital 9. Birthplace (State or Foreign Country) Virginia 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, **Funeral** 1□M 2□XF Months 239-30-3862 81 Dec. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits •how rthan "naturel", or items 23a or 28e-f ehov the Medical Examiner must be notified at Maryland Frederick Frederick 1 Yes 2 No Director 10e, Street and Number 4235 Baker Valley Road 10f. Zip Code 10g. Citizen of What Country? 21704 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14 Race - American Indian within 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed withir Depertment of Health and Mental Hygiene. Important: If item 27 ie marked other than eny injury or other treumatic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Horace Ney Body Ollie Tate 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earle F. Geisbert, Jr./Son 4235 Baker Valley Road, Frederick, Maryland 21704 Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Mt. Olivet Cemetery 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Jan. 18, 2006 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature o Funeral Service Licensee ^{22.} Name and Address of Facility Keeney and Basford Funeral Home poce MQ0021 raucera 106 East Church Street, Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Obstruction Chunk Cers /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed anding physicien and use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical igned by the ettending posteriors is detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 5 Other (specify) P.O. I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Division of Vital Records, icete hes been sig , pege 2 should b 11 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? replacement 24a. Was an autopsy performed? Director: After this certificete 2 No 1 ☐ Yes 2 ☐ No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 2 **UN**O 1 Inpatient 2 ER/Outpatient 3 DOA Certification: 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation М 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide of effer To the Hospital of within 24 hours of To the Funsral D completely filled in 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D22101 June 15, 2006

Registrar DHMH 17 Rev 1/2001

State

s of rson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

JAN 1 8 2006

		1 - For State Registrar	State of Maryland / Dep Ce	eartment of Health and Mertificate of Death	nental Hygie Reg.	1000	00866
Physi	cian	1. Decedent's Name (First, Middle, Las	51)		2. Date of Death Month	Day Year	3. Time of Death
/Med		DONALD	GARRETT	14.00 7		13 2006	5130 PM
Exam	iner	4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death	1
Funera Directo		802 W. LANVALE S 5. Social Security Number 6. S 216-20-6241		+	8. Date of Birth (Month, Day, Ye 04/15/19	ear) Coi	nplace (State or Foreign untry) MD
pug *		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits
Maryla f eho	ō	MD	BALTI				1 XYes 2 No
death with the Maryland me 23a or 28a-f ehow relust be notified at	al Director	10e. Street and Number 802 W. LANVALE S'		10f. Zip Code 21217	10g.	. Citizen of What Co USA	untry?
be filed within 72 hours after death with the Marylan tall Hygiene. and other then "natural", or iteme 23a or 28a-1 show event, the Medical Exeminer must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	12. Was Decedent Ever in U.S. Amed Forces? typyYes 2 □ No types, Give Year or Dates: 1953-1973	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Pueric 1 ☐ Yes 2 No Specify:	pecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: BI	
within 72 hc ene. then "natur	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1,40r 5+)	edent's Usual Occupation re kind of work done during most of work DO NOT use retired) UREMENT SPEC.	king 16	b. Kind of Business/l	ndustry
	o Be Co	17. Father's Name (First, Middle, Last, EDWARD GARRETT		18. Mother's Nam	ie (First, Middle, Mai ICE BLAND	iden Sumame)	
Mary nd 2 shoul lith and M 27 is mark r treumati	1	19a. Informant's Name/Relationship (LINDA GARRETT/DA	TICTIMED	ling Address (Street and Number or Run 17 S. CAREY ST., B.			ip Code)
D = = =		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification)	20b. Place of Disp cemetery, cr. GARRISO	nosition (Name of ematory or other place) N FOREST V.A. 1/20	Date 200 /06 OW	c. Location - City or INGS MILL	
permit. Pages Department of Important: If its	Suc	21. Signature of Funeral Service Lice	- /\	22. Name and Address of Facility $$ $$ $$ $$ $$ $$ $$ $$ $$ $$			NS F.H., INC
Physicia /Medica Examine	al	23a. Part1. Enter the disease, or come shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	0 . / 0	nter the mode of dying, such as cardiac	or respiratory arrest	•	Approximate Interval Between Onset and Death
	edical Examiner	Sequentially list conditions, and the sequential sequence cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): d.				- Teans
ath certif	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		B⊟Ectopic pregnancy □ Other (specify)		23d. Date of del	ivery Day Year
cords, P.O. I w requires that the de been signed by the a should be detached it	þ	Part II. Other significant conditions	contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
VITAI HECOTGS, siclen: The law requires t certificate has been signe rector, page 2 should be o	Completed				24a. Was an autopsy performe	d? prior to death?	itopsy findings available completion of cause of
r Vital Mo ysician: The is certificate hadrector, page	Be	25. Was case referred to medical examiner?	Uasattali.		th (Check only one)		
_ × v	tlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati 28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at	ome 5 Residence 28d. Describe how		pify)
DIVISION Hospital or Attendin Part hours after death. Funeral Director: After felly filled in by the fur	Certification:	3 Suicide 6 Could not to determined	De Ricca of Injury - At home form	street, factory, office	28f. Location (Stre City or Town,	et and Number or Ru State)	ıral Route Number,
	edical	29a. Certifier 1 Certifying P (Check only one) 1 Medical Exa	hysician: To the best of my knowledge, de miner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occu	, and due to the causered at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
To the within 2 To the complet	N	29b. Signature and title of certifier	em	29c. License number		1. Date signe (Mont.)	h, Day, Year)
1/0		30. Name and address of person who	ons Street Ba	Hmore MO 2	21231		
	State istrar	31. Date filed (Month, Day, Year) JAN 1 8 2006	completed cause of death (Item 23a) (Typens Street Ba	W			

	1	For State Registrar Amend Item 1. Decedent's Name (First, Middle, Las	State of Maryland #8 Per FH G853	-	tificate of D			Reg. No.	5 UU0	of Death
Physicia		LIXXIE D. GEE	,				Month 1	5 Day	2:.25	A N
/Medica		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or I	ocation of Dear		4c. County		
		316 MT. HOLLY S	KREEL		BALTIMO				NA	
Funeral Director		5. Social Security Number 6. S 431 · 28 · 2215 Usuet Residence of Decedent	7. Age (In yrs. Ias ☐ M 2 🖾 F	st birthday) Yrs.	Months Days	If Under 24 Hrs Hours Min.	8. Date of Bir (Month, Da	th 1925 ay, Year) 1924	9. Birthplace (State Country)	or Foreig
Mot W		10a. State 10b. County	10c. City,	Town or Loc	cation				10d. Inside C	City Limit
Daille Daille	ctor	MD NA	BAL	TIMOR	E				1 🔁 Yes	s 2 □ N
or 28	Funeral Director	10e. Street and Number	0-0		10f. Zip Code			10g. Citizen of V		
na 23.	era	316 MT. HOLLY	STREET 12. Was Decedent Ever in U.S.	13 V	21229	nanic Origin? /9	Specify Ves or No	US 14 Bac	e - American Indian,	
9	۵	1 Never Married 2 Married 3 ☑ Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	11	Vas Decedent of His i Yes, specify Cuban ☐ Yes 2图 No	Specify:	to Rican, etc.)	Blac	ck, White, etc.	
natur Ilgali	eted	15. Decedent's Ec	ucation de completed)	16a. Deced	lent's Usual Occupat	ion vina most of wa	rkina	16b. Kind of Bu	usiness/Industry	
	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	kind of work done du DO NOT use retired)	ang most or wo	g	roon	acount	
d other than	ပိ	8/1H GRADE 17. Father's Name (First, Middle, Last)	NA		COOK	18. Mother's Na	me (First Middle	, Maiden Sumam	SERVICE	
	To Be	ANDREW BONTON	1				AYES	, maiden daman	10)	
BEE	F	19a. Informant's Name/Relationship (19b. Mailin	g Address (Street ar			er, City or Town,	State, Zip Code)	
Health ar tem 27 is other treu		DIANE CHRISCOE	(DAUGHTER)	29 HE	EATHER TON	U. B	ALTO. M	0 21244		
it of He if item or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	COL	ace of Dispos metery, crem	sition (Name of natory or other place)	Date	20c. Location -	City or Town, State	
ury ury		4 Donation 5 Other (Specification)) M00	DLAW		01.2			DRE , MD	
Depart Imports any inj		21. Signature of Funeral Service Licer	11		. Name and Address UGHN C G					
	-	23a. Part1. Enter the disease, or com shock, or him rifailure. List only	plications that caused the death	Do not ente	51 BAUO. NI	ATU PIKE	BAUTO M	10 21229	Approxima	ate
ysician Medical caminer		shock, or hand failure. List only Immediate Cause (Final disease or condition resulting in death)	a	e (ances				Interval Be Onset and	Death
and -transit	Examiner	Sequentially list conditions, 1 any, leading to minimize cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Doe to for as a consequence.							
ysicie ne bur	cal		Due to (or as a conseque	erice oi).						
by the attending phy tached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown	23c. If yes, outcome of pregnand 1□Live birth 2□Fetel of 4□Pregnant at time of dea 9□Unknown	death 3□	Ectopic pregnancy Other (specify)				te of delivery anth Day	Year
ang eq	þ	Part II. Other significant conditions of	ontributing to death but not result	lting in the ur	nderlying cause giver	n in Part I.			tribute to the cause of	/
been s should	eted							Yes 2 □ No		Unknow
icete has t r. paga 2 s	Completed						24a. Was auto perfe 1 Yes	opsy ormed? 0 2000 1	Were autopsy findings prior to completion of death? 1 ☐ Yes 2 ☐ No	s availab cause o
	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑No	Hospital: 1 ☐ Inpatient 2 ☐ E	D/O	Other	~	ath Check only			
	2	27. Manner of Death	28a. Date of Injury 2	R/Outpatien 28b. Time of	28c. Injury	at Nursing		idence 6 Oth how injury occur		
death. ctor: After y the funer	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Work' M 1 □ Y	? es 2 □ No				
within 24 hours efter death To the Funeral Diractor: completely filled in by the	Certification;	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	me, farm, str	eet, factory, office			(Street and Numb wn, State)	per or Rural Route Nui	mber,
within 24 hours e To the Funeral I completely filled	Medical	29a. Certifier (Check only one) Certifying Ph	ysician: To the best of my knowniner: On the basis of examination and manner stated.	vledge, death on and/or inv	n occurred at the time vestigation, in my op	e, date and place inion, death occ	e, and due to the urred at the time,	cause(s) and ma , date and place,	anner as stated. and due to the cause	(s)
withir To th comp	×	29b. Signature and title of certifier		A =	29c. License		/ \		d (Month, Day, Year)	
		Kachels		ND		1576			5/06	
7		30. Name and address of person who	completed cause of death (Item :	23a) (Type,	Print) Baltm	ne N	1/ 2	(3) \		
10	1	Kacholleding	1406 911/m 11	VC I	2001 1 1 1 LAL	UN		100		

State of Maryland / Department of Health and Mental Hygiene)

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						Cen	tificate	of D	Peath		Reg. No.	000	00	000
	D		I. Decedent's Name (First, Middle, L.	ast)						2. Date of I	Death	Year	3. T	ime of Death
	Physiciar /Medica	-	Ja	mes H. Ga	affney					Janua			13	1:20 AM
1	Examine	r 4	a Facility Name (If not institution, gi					4b	. City, Town,	or Location of De	ath 4c.	County of Deat	h	
			Brooke Grove Rehab.	& Nursing Ce	nter					Spring	Mo	ontgome	ry	
Ì	Funeral Director		215-38-3711	Sex 1 X M 2 □ F	96	Yrs.	If Under 1 Months E	Year Days	If Under 24 I Hours N	Ain. 8. Date of E (Month, I Decembe	Birth Day, Ye <i>ar)</i> r 26, 1	9. Birt Co Neb	nplace (S untry) rask	State or Foreign .a
	pue ≱	-	Jsual Residence of Decedent 0a. State 10b. County		10c. City, Tow	vn or Loc	ation							side City Limits
	r 28a-f show		Maryland Montgor	nary	•									JYes 2⊠No
	the h	3	Oe. Street and Number	пету	Sai	iiuy i	Spring 10f. Zip Co				10g Citis	zen of What Co	untry?	
	filer death with the Ma r Items 23a or 28a-f s never must be notified Einneral Director	5	1641 Hickory Kno	11 Pond			102.0		0860					
	feath ms 23	<u> </u>	Marital Status	12. Was Decedent E	ever in U.S.	13. W	as Deceden			(Specify Yes or I		ed Stat		lan,
21215-0020	urs e	2	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:			Yes, specify □ Yes 2∑		Specify:	uerto Rican, etc.)		Black, White Specify: Wh	e, etc. nite	
5-0			15. Decedent's E	ducation ade completed)	16a	. Decede	ent's Usual C	Occupati	ion iring most of	workina		nd of Business/		
21	_ 200	1	Elementary/Secondary (0-12)	College (1-4or 5-	+)			retired)				erstate ommissi		merce
2	be filed withintal Hygiene. Id other than event, the M	3		5+	A	ttor	ney						011	
an	12 should be filed von and Mental Hygie is marked other traumatic event, If To Re Co	Ď	7. Father's Name (First, Middle, Las	<i>)</i>						Name (First, Midd		Sumame)		
Ž	d Ment d Ment marked marked		James B. Gaffney	(Time Brint)	101	h Mailine	Address (C			red Holm		Town Class 7	in Code	
Maryland	nd 2 sl lth an 27 is r traur		19a. Informant's Name/Relationship James Michael Gaf							Rural Route Num				į.
e j	s 1 end 2 should f Health and Mer item 27 is marks other traumatic	_	Oa. Method of Disposition	They/Son	20b. Place o cemete	of Disposi	ition (Name	of	Lbson .	Island, N	20c. Loc	and 210. cation - City or		ate
Baltimore,	permit. Peges 1 end Depertment of Health Important: If Item 27 any Injury or other to Once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 🖾 Other (Special Control of the Con	(y)Entombment	Gate of	Heav	en Cem	nete	ry	Jan. 18, 2006		•		Maryland
Ba	permi Deper Impor any ir	1	21. Signature of Funeral Service Lice		M0130	Rob	ert A. West 1	Pump	hrey Fu	meral Home	Rock kville	ville, In e, Maryla	nc. nd 20	0850–2805
		1	23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused to	the death. Do e.	not enter	the mode o	f dying,	such as card	diac or respiratory	arrest,		Appro	oximate ral Between
No.	Physician	١.										i	Onset	t and Death
	/Medical Examiner	0	mmediate Cause (Final disease or condition resulting in death)	a. MYOCAR	201AL	T	NFAR	CTI	ON			-	HOL	LES
			oraning in docum		Oue to (or as e							1		
X	nsit			b. CORONAR				SEP	tst			1		
,	executed in and riel-trensit	3	Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury	U	Due to (or as a	consequ	ence of):					1		
292		1 0	nat initiated events	C	Due to (or as a	concodille	ange of):			_		- !		
68760,	certificate be executed ding physiclan end ise as the buriel-trensit	į (esulting in death) Last	U	de to (or as a t	conseque	5110 0 01).					1		
Box	anding use a			d										
w.	death e atte	F	art II. Other significant conditions	contributing to death but	t not resulting i	n the unc	deriving caus	se aiven	n in Part I.	23b. Die	tobacco u	use contribute	to the cr	ause of death?
P.O.	es that the death igned by the attenbe deteched for u				-					1	Yes 2	□No 3⊠Pr	obably	4 Unknown
	as the gened be de	-	CHIZONIC OBSTEU	LITTLE FALM	WNHEY	Dis	EASE,			-				
of Vital Records,	The law requires that the death sets hes been signed by the attent page 2 should be deteched for u Completed by Physician		CEREBROVASCULA	7 DICEAC	F					24a. Wa	s an autop: formed?	a	vailable	
ပ္ပ	law re es be 2 sh	-	CE CE IS TO THE POST OF	ie Otschi								C	ompletion death?	on of cause
<u>ہ</u>	The page									10	Yes 2🛚	No 1	□Yes	2□ No
/ita	ertific actor,	2	5. Was case referred to medical examiner?							Death (Check only	one)			
£	Physician: rthis certific iral director,	: _	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatien			3□ DOA	Other:	4 Los Nursing	g Home 5□Re			ify)	
Ē	Ing P	2	7. Manner of Death 1 ⊠Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28b.	Time of Injury	28c.	Injury e Work?		28d. Describe	how injury	occurred		
Sio	Attending or death. actor: After by the fune		2 Accident investigatio 3 Suicide 6 Could not b				М		es 2 No	20/ 1	(0)			Atombo
Division	tal or Attending P so filer death. at Director: After to the funers and in by the funers Certification:		4 ☐ Homicide determined		ry - At home, fa (Specify)	arm, stree	et, factory, of	ffice		City or To	(Street and own, State)	d Number or Ru	rai Houte) Number,
	pital ours e eral D		9a. Certifier	To the best of		n donth a		b = 4i===	d-10 0 0 d - 10		(-)			
	To the Hospital or Attending Physician: The law within 24 hours efter death. To the Funeral Diractor: After this certificate has completely filled in by the funeral director, page 2. Medical Certification: To Be Compl	1		nysician: To the best of miner: On the basis of a and manner state	examination en	d/or inve	stigation, in	my opir	, date and pla nion, death of	ccurred at the time	, date and	place, and due	to the ca	iuse(s)
	ithin of the omple		9b. Signature and title of certifier	and manner state			29c. Li	icense r	number		29d. Date	signed (Month	, Day, Y	ear)
			* TENALIS	M			97:	77	100		1.0			
	XI	2	0. Name and eddress of person who	completed cause of de-	ath (Itam 23a)	(Type P		וענ			JANI	MAKCA 11	0 (2006
	Jox,	3	TEN E. HOWE .	154 N. A				VILLA	AMSPO	RT MC) 7	1795		
	State	3	1. Date filed (Month, Day, Year)	32. Registrar		- 7	, 00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	. 11/ (1 1/2		
	Registrar	-	JAN 1 8 2	inne 🛝	20	A CO								

			1 - For State Registrar	State of	Marylan		artmen rtificat					Reg. No	000	008	69
	Physici		1. Decedent's Name <i>(First, Middle, Las</i> E1sa Jos	ephine	Gann	on					2. Date of D Month Januar	Da	2006ar	3. Time of 10:04	
1	/Medic Examir		4a. Facility Name (If not institution, give	street and numi			-	Town, or	Location o			40	County of Death)	
- A-	Funeral Director		5. Social Security Number 6. Security Number 11 Sec	x 7 □M 2g F	. Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bi (Month, D Oct 28	irth ay, Year 19	9. Birth Coi 38 Wash	nplace (State of intry) ington	
	e Maryland Ba-f ehow	ctor	10a. State 10b. County Maryland Montgome	ry		y, Town or Lo ethesda								10d. Inside Ci	
	3a or 2	i Dire	10e. Street and Number 4702 Glenbrook Par	kway			10f. Zip	814				-	itizen of What Co ced State		
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other then "natural", or iteme 23a or 28a-f ehow any injury or other traumatic event, the Medical Examic art is ust be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give Year or Dat	es? No		Was Deced f Yes, spec 1 ☐ Yes	offy Cubar	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto F	cify Yes or N Rican, etc.)	0-	14. Race - Amer Black, White Specify: Wh	, etc.	
21215-0036	within 72 horiens. Internature	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		4or 5+)		dent's Usua kind of wo DO NOT us arian	rk done d se retired,	tion uring most	of working	19		(ind of Business/I	ndustry	
Maryland 2	ould be filed Mental Hyg arked other stic event,	To Be C	17. Father's Name (First, Middle, Last) Wilfred H. Co	orridon							(First, Middle McHug		n Sumame)		
Man	nd 2 shoulth and 27 is mur		19a. Informant's Name/Relationship (7 Eileen Gannon/daug										or Town, State, Z Marylan		'
altimore,	Pages 1 and the properties of the sant: If item arry or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☑ Donation 5 ☐ Other (Specify			Place of Disponentery, cremetery, cremetery, cremetery, cremeters at onlice	natory or o wn Un a I Do	ther place iver natio	sity	Janua 17, 2	2006	Was	ocation - City or I		
Balti	permit. Departrimports any inju		21. Signature of Funeral Service Licens	M000		Be	Name and these these	d Addres 1a-Cr da, N	s of Facility levy (lary1a	Robe Chase and	20814	. P75	Bhrey Fu Wisco	neral l nsin A	Home Venue
8760, 🕸	Continued be executed with the province of attending physician and province as the burial-transit	dical Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a		uence off	A	RK H	YTI	+M	IA			Interval Bet Onset and I	
P.O. Box 6	that the death certifics ed by the attending pt detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		th 2 Feta	ildeath 3□	Ectopic pr Other (sp						23d. Date of deline Month		rear .
	ires sign d be	ρ	Part II. Other significant conditions co	entributing to dea	th but not res	ulting in the u	nderlying c	ause give	n in Part I.			tobacco Yes 2	use contribute to	the cause of d	
of Vital Records,	The ate h page	Completed									24a. Wa: auto perf 1 Yes	ormed?	death?	opsy findings ompletion of c	available ause of
<u> </u>	/sician s certif	To Be	25. Was case referred to medical examiner?	Hospital: 1 □ Ini	patient 2	ER/Outpatier	nt 3 DC	Othe	-	of Death	(Check only	1	6 □Other (Spec	(64)	
ion of	Attending Physician: It death. Cotor: After this certification is the funeral director.		27. Manne of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of		28b. Time of Injury		8c. Injury Work		2	8d. Describe	-		·· y /	
Division	i Dir Q	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of building	f Injury - At ho g, etc. <i>(Specil</i>	ome, farm, str	eet, factory	/, office		2	8f. Location City or To	(Street a	nd Number or Ru e)	ral Route Num	ber,
	To the Hospitat within 24 hours of To the Funeral is completely filled	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	vsician: To the basiner: On the basiner	is of examina	wledge, death tion and/or in	h occurred vestigation	at the tim , in my op	e, date and inion, deat	d place, a h occurre	nd due to the	cause(s , date an	and manner as d place, and due	stated. to the cause(s)
	To th within To th compl	Me	29b. Signature and tyte of certified	15			290	License	number	u			ate signed (Month		
	On		30. Name and address of person who o	ompleted cause	of death (Iten	п 23а) (Туре,	Print)	10	001	-		01	11+12	006	
	4		Bradley James Hur		D. 104 gistrar's Signa		necti	cut	Avenu	ıe Ke	nsingt	on,	Maryland	1 20895	
	Sta Registi		INN 1 Q 2	69	Latina a	M A	2342	D							

	for State Registrar	State of Maryland / Depa	artment of Health and Nartificate of Death		2006 00970
Physician	Decedent's Name (First, Middle, Last) JOHN JACOB GEI			2. Date of Death Month Dat JANUARY 6	3. Time of Death 10:25 P. M
/Medical Examiner	4a. Facility Name (If not institution, give s FOREST HILL HEAL	Street and number) TH & REHAB CENTER	4b. City, Town, or Location of Death FOREST HII	4c	County of Death HARFORD
Funeral Director	5. Social Security Number 6. Sep 200-16-2082	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Sept 26, 19	9. Birthplace (State or Foreign Country) 926 Pennsylvania
Maryland in day	10a. State 10b. County MD Harford	10c. City, Town or Lo		-	10d. Inside City Limits 1 Tyes 2 No
th with the Mar 23a or 28e-fs 11 Le routifs ai Director	10e. Street and Number 317 Stevens Circl	e #2A	10f. Zip Code 21001	10g. Cit	tizen of What Country? USA
5-0036 72 hours after death with the Maryland retural; or items 23a or 28e-f show digal Examinative notified at etded by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	1 X Yes 2 □ No	Was Decedent of Hispanic Origin? (Spiff Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: white
2121 ad within rgiene. er than " i. If e Mes	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+) (Give life.	dent's Usual Occupation kind of work done during most of work DO NOT use retired) f employed	ing 16b. K	(ind of Business/Industry unk
Maryland d 2 should be file th and Mental Hy tr is marked oth traumatic event To Be (17. Father's Name (First, Middle, Last) Robert William G		Loretta	a (First, Middle, Maiden a May Lonsd	lorf
Baltimore, Mary permit. Pages 1 and 2 shc Department of Health and importent: if item 27 is m any injury or other traum once.	19a. Informant's Name/Relationship (Ty William Geiger/son 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R 1 □ Stormation 5 □ Other (Specify)	20b. Place of Dispo	Armistead Filler sition (Name of matory or other place)	Lane Lovet	
Balti permit. Departi importe any inju	21. Signature of Femeral Service License Ronald S. W.	lade, Director St	2. Name and Address of Facility tate Anatomy Board altimore, MD 2120	655 W. Bal	ltimore Street
certificate be executed viding physician and lise as the burial-transit and live as the burial-transit and live as the burial-transit and live as the burial-transit and live as the burial-transit and live as the burial-transit and live as the burial-transit and live are the live and live an	Shock, Ir hear failure. List only or Immediate Ca. e (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	0	Cementy	in respiratory arrest,	Approximate Interval Between Onset and Death
Geath certific death certific e attending p of for use as iclan/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		⊒Ectopic pregnancy] Other (specify)		23d. Date of delivery Month Day Year
	Part II. Other significant conditions cor	ntributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
Recont The law are has be page 2 st				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
on of ling Phy. After this funeral d	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatient 2 ER/Outpatien 28a. Date of Injury (Month, Day Year) Injury	nt 3 DOA Other. Nursing Ho	me 5 Residence 28d. Describe how injure	
Division c tai or Attending P is after death. at Director: After t led in by the funera Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street ar City or Town, State	nd Number or Rural Route Number, e)
the Hospi nin 24 hou the Funer ppletely fill nedical	one)	sician: To the best of my knowledge, deat ner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurr	ed at the time, date and	d place, and due to the cause(s)
with To 1	29b. Signature and title of certifier	D	29c. License number		ite signed (Month, Day, Year)
	DR. DAVID DUNN -	ompleted cause of death (Item 23a) (Type, 615 W. MACPHAIL R	Print) OAD - BEL AIR, N		
State Registrar	31. Date filed (Month, Day, Year) JAN 1 8 201	32/Registrar's Signature	selv		

			1 - State Registrar	State of Maryland /			f Health and of Death		erre() ()	6	00871
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day	Year	3. Time of Death
	/Medic	al	SARAH 4a. Facility Name (If not institution, give s	traat and number)		GINSE	M, or Location of De	JANUARY	15 20 4c. County of		11:10A ^M
	Examir	er	JEWISH CONVALESCEN	·		BALT]		auı		TIMOF	2F
t.	Funeral Director		5. Social Security Number 6. Sex 218-01-7491		rirthday) Yrs.	If Under 1 Y					ace (State or Foreign
	land w		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Loc	ation				10	d. Inside City Limits
	Mary I-f sh	tor	MD N/A		BALT:	IMORE					1 ¥Yes 2 □ No
	or 284	Oirec	10e. Street and Number			10f. Zip Co		10	g. Citizen of W	hat Count	,
	s 23a	erai	7201 VALLEY COUN		40.14	1 2 1 1	21208	(01-)	14 0-		USA
36	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examinar must be mailled at ance.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 N No If Yes, Give Year or Dates:	lf	Yes, specify	of Hispanic Origin? Cuban, Mexican, Pue No Specify:	(Specify Yes of No- erto Rican, etc.)		- America k, White, e	
2-0	72 ho	eted	15. Decedent's Educ (Specify only highest grade			ent's Usual O	ccupation one during most of w	rorkina	6b. Kind of Bus	siness/Ind	ustry
21215-0036	within lene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	SPERSON	tired)	_	RETAIL	PRODU	JCE
	e filed al Hyg other vent,	BeC	17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle, N	laiden Sumame	9)	
ylaı	Ould b	Tof	BENJAMIN			SBURY	MOLL				BARTZ
Maryland	id 2 sh lith and 27 is n traun		19a. Informant's Name/Relationship (Type DEBORAH GROSSBLAT					Rural Route Number, - LUTHERVII			
	ss 1 ar of Hea Item 2		20a. Method of Disposition	20b. Place	of Dispos	sition (Name o	if .		20c. Location - 0		
Ē	Pege ment c ant: If ury or		1 🕅 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State	•	•	AGODOL 1/	17/2006	ROSE	DALE,	, MD
Baltimore,	permit. Depart Import any inj		21. Signature of Funeral Service License	utten				SOL LEVINS N ROAD - P			
4			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused the death. Do e cause on each line.	not ente	or the mode of	dying, such as cardi	ac or respiratory arre	st,		Approximate Interval Between Onset and Death
in the	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence	vez	pull	7 Drug	1		1	nates
	Examiner		Sequentially list conditions, b.	Mac	بالحد	Pita	Progeton	_			16
	bd sit	iner	ri any, teading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons uence	e of):	^					,
	and and al-tran	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence	> e of):	2					rears.
38760,	cate be executed physicien and the burial-transit	dicai E	d								
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P.O. Box	that the death certifi ed by the attending detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deal 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregn Other (specif			23d. Date Mon	of deliver th i	y Day Year
	law requires that the as been signed by th 2 should be detache	by Ph	Part II. Other significant conditions conf	tributing to death but not resulting	in the un	derlying cause	given in Part I.	23e. Did tob	acco use contri	bute to the	cause of death?
ords	w require been sig should b		Devente	congerte	He	mt 4	Talus	1 □ Ye	s 2 140	3 🗌 Proba	bly 4 ∐Unknown
ecc	e law r has be je 2 sh	Completed						24a. Was an autopsy	/ pi	ior to com	sy findings available ipletion of cause of
al H	T ele								☑No 1	eath?	2 □ No
<u>=</u>	Physicien: r this certifice ral director, p	To Be	25. Was case referred to medical examiner? 1 Tes 2 No	ospital: 1 Inpatient 2 ER/C	Outnatient	3□ DOA	Other	eath (Check only one Home 5 Reside	-	r (Spanific	
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Division of Vital Records,	after d Direct Direct J in by	Certification;	4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	et, factory, of	ice	28f. Location (Str City or Town,	eet and Numbe State)	ror Rural	Route Number,
_	To the Hospital or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical C	(Check only 2 Medical Examin	To the Sest of my knowledger: On the basis of examination a	ge, Jeath	occurred at the	ne time, data and pla	e, and due to the cal curred at the time, do	use(s) and man	Kilof as sta	tha cause/e)
	To the P within 24 To the P complete	Medi	one) 29b. Signature and title of certifier	and manner stated.			cense number		d. Date signed		
	8 4 8 4		130-11	\searrow \bigwedge .		7	10507	9	1-14	10	u, rour/
1			30. Name and address of person who con	mpleted cause of death (Item 23a	(Type, F	Print)	W. JORGE		0.0	S	10 31110
2	A 100	4	J. STEVEND W	MRKGULS M	V	= 10	MELEN	XS MI	MH	/, t	5, 411
	Sta Registi		31. Date filed (Month, Day, Year) JAN 1 8 200	32 Registrar's Signature	Lon	of 1					J

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

3/8		Pleas	e Type or Prin	it in Black I	ndelible ink. Ensure	All Copies	Are Legible.	
		For	State of Ma		partment of Health and	d Mental Hy	giene 006	00872
		1 - State Registrar		C	ertificate of Death		Reg. No.	
Physici	an	Decedent's Name (First, Middle,	Last)	11.1		2. Date of De _Month	Day Year	3. Time of Death
/Medi		WATIOH L	Enise	401+		Januar	cy [™] 15 200	6 3:14 AM
Examir	ner	4a. Facility Name (If not institution,	give street and number)		4b. City, Town, or Location of De	eath	4c. County of De	ath
F		Sinai Hospital 5. Social Security Number	6. Sex 7. Age	e (In yrs. last birthda	Baltimore Baltimore Balti	Irs. 8. Date of Bi	N/A	irthology (State or Foreign
Funeral Director	١.	218-78-9733	1□M 254F	Yrs.		lin. Month, Da	ay, Year)	nthplace (State or Foreign
9		Usual Residence of Decedent				Miny	22,1957 /	nticfirma
how	_	10a. State 10b. County		10c. City, Town or				10d. Inside City Limits
Se-f	5,	MARYLAND MA		Baltime	ORE			1, Yes 2 No
with th	ä	10e. Street and Number	2		10f. Zip Code		10g. Citizen of What C	*
is 1 and 2 should be filed within 72 hours after death with the Maryland of Heelth end Mental Hygiene. Item 27 te marked other then "neture!, or items 23e or 28e-f ehow other treumatic event, if a Medical Examinational centuitied at	by Funeral Director	601 Mc CAB		Tues in II C	2/2/2	1/0 4 //		
Hem Hem	Š	11. Marital Status 1 Never Married 2 Marrie	12. Was Decedent 6 Armed Forces? d 1 Yes 220		 Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu 	(Specify Yes or Ni Jerto Rican, etc.)	0- 14. Race - Am Black, Wh	
urs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	.0	1 ☐ Yes 2 No Specify:		Specity:	AMERICAN
2 ho	Completed	15. Decedent's	Education		cedent's Usual Occupation		16b. Kind of Busines	
thin 7	lg l	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5	life	ve kind of work done during most of DO NOT use retired)	working	1	
ed wi	ပ္ပ	2 4	Alan		ecretary		GOVANS	School
d oth	Be	17. Father's Name (First, Middle, L.	15t)		18. Mother's i	Name (First, Middle	, Maiden Sumame)	
ould Men Parke	ဥ	CHRC HOI	<i>'T</i>		Dope	thy A	Ki	
12 sh h end 7 le m		19a. Informant's Name/Relationshi	p (Type, Print)	19b. Ma	tiling Address (Street and Number or	Rural Route Numb	per, City or Town, State,	Zip Code)
1 and deelth em 27 ther tr		20a. Method of Disposition	O JR.	20h Place of Die	Position (Name of	Date Date		HAND 21218
permit. Pages 1 and 2 should be filed withir Depertment of Heelih end Mental Hygiene. Important: If item 27 ie marked other then may injury or other treumatic event, II a Manance.		1 Burial 2 ☐ Cremation		cemetery, c		24 May 1906	20c. Location - City o	
it. Partment		4 □ Donation 5 □ Other (Special Service Li			emerial tark		Woodlaws	
Departition Department Importment In Importm		21. Signification of Pulleral Service Co	Certision		clarace on lassicas	e Funer	AC SERVICE	1212
		23a. Pad1. Enter by disease, or c	omplications that caused	the death. Do not a	3405 W. FRANKLIO enter the mode of dying, such as card	Street -	NATITITIENE	Approximate
Discontinuo		shoot, or have failure. List of immediate Cause (Final	niy one cause on each iin	10.		and of roophatory o		fnterval Between Onset and Death
Physician /Medical		disease or condition resulting in death)		a consequence of):	unies			
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ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome a 1 ☐ Live birth	2 Fetaf death	3 □Ectopic pregnancy		23d. Date of de Month	
the e	Sic	1 ☐ Yes 2 ☐ No 9 ☑ Unknown	4☐Pregnant at 9☐Unknown	time of death	5 Other (specify)		Month	Day Year
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sicia certi	o Be	25. Was case referred to medical examiner? 1 X Yes 2 No	Hospitaf:	40tno	Other	Death Check only		
Phy or this oral d	⊢	27. Manner of Death	1 Inpatie	y 28b. Time	of 28c. Injury at		how injury occurred	
ading th: Afte	to	1 □Natural 5 □ Pending 2 □ Accident investiga		Year) Injun	Work?	-		, COLLISION WITH
Atter r dea ector	ifica	3 Suicide 6 Could no	ot be 28e. Pface of Inju	iry - At home, farm,	11	28f. Location (Street and Number or F	
s efte	Certification;	4 Homicide determin	building, etc	(Specify)		900 But Co	wn, State) 20 SPRING BAW	DUDGE UN
hour hour nere ly fille		29a. Certifier 1 Certifying	Physician: To the best of	of my knowledge, de	ath occurred at the time, date and pla	ace and due to the	cause(s) and manner a	e clated
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours effer death. To the Funeral Director: Affer this certificate hes been signed by the ettending physicompletely filled in by the funeral director, page 2 should be detached for use as the	edicai	(Check only 2 Medical E	xaminer: On the basis of and manner sta	examination and/or	investigation, in my opinion, death of	ccurred at the time,	date and place, and du	e to the cause(s)
To t Com	Σ	29b. Signature and title of certifier	d		29c. License number		29d. Date signed (Mon	ith, Day, Year)
		Mounte	The Shul	e wy	OCME		January 15.	2006
σ_{i}		30. Name and address of person w	ho completed cause of de	eath (Item 23a) (Typ			candary 1)	, 2000
1		MARYARION	1. KURE	U	111 Penn Str	eet Balti	more. Marvi	land 21201
Sta	ate	31. Date filed (Month, Day, Year)	32 Registra	ar's Signature	. 23		, , , , , ,	

State Registrar

Sporte

DHMH 17 Rev 1/2001

ORIGINAL

		1 - For State of Mary Registrar		artment of Health and I		giene 006	00873
		1. Decedent's Name (First, Middle, Last)	. / /		2. Date of Dea	ith	3. Time of Death
Physici /Medic		KONNEIL KobeRt F	tolt		Januar	y 15 2006	3:15 A M
Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death	1	4c. County of Death	
Europol		West Cold Sring Lane @ St. Ge 5. Social Security Number 6. Sex 7. Age (Ir	eorge's F		8. Date of Birth	N/A	lace (State or Foreign
Funeral Director		215-88-1791 1XM 20 F 30	Yrs.	Months Days Hours Min.	(Month, Day	24 19 75 MAR	1/And
PU &		Usual Residence of Decedent 10a, State / 10b, County 10	c. City, Town or L	ocation			0d. Inside City Limits
Marylan f ahow	ō	thouland 1/2	Bartino				1 XYes 2 □ No
or 28a-f	Director	10e. Street and Number	MITATIO	10f. Zip Code	1	10g. Citizen of What Cour	ntry?
th with	aiD	601 ME CABE ANE		21212		USA	
after dea	Funeral	11. Marital Status 12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White,	
urs aft	by F	1 Never Married 2 Married 1		1 ☐ Yes 2 ☐ No Specify:		Specity: As A	American
be filed within 72 hours after death with the Maryland be filed within 72 hours after death with the Maryland by diene. The Widelal Examinar must be notified at swent, the Medical Examinar must be notified at		15. Decedent's Education (Specify only highest grade completed)		edent's Usual Occupation e kind of work done during most of wor	kina	16b. Kind of Business/In	dustry
ithin n	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life.	DO NOT use retired)			
Hygiel And And And And And And And And And And		17. Father's Name (First, Middle, Last)	Dr	/	ne (First Middle	Maiden Sumame)	(IDESS
id be ental ked o	To Be	TYRONE TULER		Velando	thit	,	
2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Men	-	19a. Inf. mant's Name/Relationship (Type, Print)	19b. Mail	ing Address (Street and Number or Ru	ral Route Number	r, City or Town, State, Zip	Code)
end 2 ealth m 27 I		William Reid- (Step father)	601	Mª CAbe AUE.		DEE MARYLA	
Pages 1 nent of H int: If Ite		1 Burial 2 ☐ Cremation 3 ☐ Removal from State		matory or other place)	224 1706	20c. Location - City or To	
그 문원을		4 □Donation 5 □Other (Specify) 21. Shara are of Funeral Service Licensee		Emarcial Parici		etodawy 1	MARY MANS
Depermit Depermit any ir.		Janes m. Cenoloss	11	2. Name and Address of Facility Ancy M. LLACCACE FOR FOR W. FRAKKIN	THERACE	PROTE MARY	and -20129
		23a. Part. Enter He disease, or complications that caused the shock, or heart failure. List only one cause on each line.					Approximate Interval Between
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The lay te hes age 2	Completed				autops	sy prior to co med? death?	psy lindings available mpletion of cause of
sician: The law scertificate hes t irector, page 2 s	BeC	25. Was case referred to medical examiner?		26. Place of Dea	th (Check only or		2 LI NO
hysic hysic this ce	은	1 XX es 2 ☐ No Hospital: 1 ☐ Inpatient	2 ER/Outpatie			ence 6 XOther (Specif	y) Scene
ding P. After funera	tion:	27. Manner of Death ☐ Natural ☐ Pending ☐ Macrident investigation		Work?		ow injury occurred	Car
Atten r deat r deat octor:	Certification:	3 Suicide 6 Could not be	At home, farm, s	[13	28f. Location (S	Treet and Number or Aura	
tal or selfe	Cert	4 Homicide determined building, etc. (5	_		acobie in c	n, state) DLPSPRIKKUS	NO BUTWA
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours effer death. To the Funeral Director: After this certificete has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check only contact of the best of many contact of the best of	amination and/or i	ith occurred at the time, date and place nvestigation, in my opinion, death occu	, and due to the c	ause(s) and manner as s date and place, and due to	tated. the cause(s)
o the ithin 2 o the omplet	Med	one) and manner stated 29b. Signature and title of certifier {		29c. License number		29d. Date signed (Month,	
F ≤ F 0		Illauria ma Youle	2 NW	OCME		January 15	
2		30. Name and address of person who completed cause of death	ı (İtem 23a) (Type	, Print)			, 2000
		MANUAL D. KORY	Cianat	111 Penn Street	Baltim	nore, Maryla	nd 21201
Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's	Signature				

			1 - For State Registrar		State of N	Marylar	nd / Depa		t of H	ealth a	and M	•		ZUUD	00	874
	Physici /Medic	al	1. Decedent's Name (Fire	ov Hicl	KS							2. Date of D Month Jan. 7	, 2	2006 Yea	8	ne of Death
	Examin Funeral	er	4a. Facility Name (If not Inc.) 210 Wicklor 5. Social Security Number 219-16-4144	w Rd.		Age (In yrs.	last birthday)	Ferne	dale 1 Year	If Under		8. Date of Bi (Month, D Sept.	A	ar)	nde1	ate or Foreigr
	Director		Usual Residence of Dece				ty, Town or Lo	cation				Sept.	25,	1924	Mary1a	nd de City Limits
	th the Mary or 28a-f sh	Director	MD A	nne Arı	ınde1	Fe	rndale	10f. Zip					10g.	Citizen of What		Yes ½½ No
2	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or Itams 23a or 28a-f show evant, I're Madical Exaniner rust be notified at	by Funeral	210 Wicklow 11. Marital Status 1 Never Married 3 Widowed 4 🔀	2 Married	12. Was Decede Armed Force FY Yes 2 [If Yes, Give Year or Date.	^{s?} №194	.5	Was Deced f Yes, spec 1 ☐ Yes 2	ent of Hi			ecify Yes or N Rican, etc.)	0-	USA 14. Race - Ar Black, WI Specify:		n,
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טומ, ייום			Wayne K. H: 20a. Method of Disposition 1 ☒ Burial 2 ☐ Cre	icks -	Son		2201 (Place of Dispo	Gay lav	n D:	r. Ba	ltim	ore, M	D 2	1227 Location - City	or Town, Stat	9
baltillole,	permit. Pages 1 and 2 Department of Health & Important: If Itam 27 Is any injury or other tra once.		4 Donation 5 D	Other (Specify	4	Lo	22	. Name and	d Addres	s of Facilit	y Lou	don Pa	rk	ltimore Funeral MD 2122	Home	
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	_	ai Examiner	Sequentially list condition if any, leading to immedicause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	ns, late	Due to (or a	nary . as a consec as a consec		Disea	ise						12 ус	ears
	that the death certificate be executed the by the attending physician and detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent preg in the past 12 mont 1 □ Yes 2 □ No 9 □ Unknown		23c. If yes, outcon 1 Live birth 4 Pregnant	2 ☐ Feta at time of c	al death 3	Ectopic pre						23d. Date of d Month	elivery Day	Year
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5	ding Phys h. After this funeral di	To B	examiner? 1 \(\text{Yes} \) 2\(\text{No} \) 27. Manner of Death 1 \(\text{Natural} \) Natural 2 \(\text{Accident} \)	Pending investigation	28a. Date of Ir (Month, I		ER/Outpatier 28b. Time of Injury		lc. Injury Work	r 4□Nu	rsing Hon	ne 5X Res 28d. Describe	idence	6 □Other (Sp ijury occurred	pecify)	
	spital or Attanyons after deathurs after deathurs Director: y filled in by the	Certification:	4 🗍 Homicide	Could not be determined	building,	etc. (Specia	fy)					City or To	wn, St	•		Vum ber,
	To the Hospital or At within 24 hours after of To the Funeral Dirac completely filled in by	Medical	29a. Certifier (Check only one)	Medical Exam	ysician: To the be niner: On the basis and manner	s or examina	owledge, death ation and/or in	restigation,	t the time in my op License	inion, deal	d place, a	and due to the ed at the time,	date a	(s) and manner and place, and di	ue to the caus	
4		100	30. Name and address o		completed cause of) of death (Iter	m 23a) (Tvpe.				F					
NK.	Sta	ıtė	DAVID A				ADIJO ature		RK	Driv	4 (bleu l	Sui	kie, M	(1) 2	106/

		•		of Maryland / Depa	artment of Health and Martificate of Death	-	P 006 (00875
- 6	Physicia	an	1. Decedent's Name (First, Middle, Last) Ethel Holloway			2. Date of Death Month	pay year	3. Time of Death
	/Medic Examin	al er	4a. Facility Name (If not institution, give street and	Hospital	4b. City, Town, or Location of Death		4c. County of Death	0.007
67	Funeral Director		5. Social Security Number 6. Sex 1	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 05 11		lace (State or Foreign try) SC
	yland how		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo			11	Od. Inside City Limits
	Ba-f si	Director	MD NA	Baltimo		100	Cisi	1 XYes 2 No
	3a or 3	i Dir	3700 Copley Road		10f. Zip Code 21215	109.	Citizen of What Coun	try :
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23s or 28s-f show eumatic event, the Madical Examinar must be collided at	by Funerai	11. Marital Status 1 Never Married 2 Married 1 Yes,	s 2 TXTNo	Was Decedent of Hispanic Origin? (Sr if Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2☑ No Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No- pecify Yes or No-	14. Race - Americ Black, White,	
200	72 hou	eted	15. Decedent's Education (Specify only highest grade complete	16a. Deced (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	king 16b	. Kind of Business/Inc	lustry
Maryland 21215-0036	within iene. than	Completed	Elementary/Secondary (0-12) College 8th grade na	e (1-4or 5+)	letary Aide		sewood H	ospital
g	al Hyg al Hyg d other	BeC	17. Father's Name (First, Middle, Last)			ne (First, Middle, Maid	den Sumame)	
<u>ya</u>	should be ind Mental s marked o umatic ave	Tol	Charlie Edwards	10h Maille	Lonie M		tura Tour State Zin	Code
	s 1 and 2 should i Health and Men item 27 is marke other treumatic		19a. Informant's Name/Relationship (Type, Print) Wrvant Holloway-Hus		Copley Road,			1215
altimore,	ges 1 and 3 to 1 to 1 to 1 to 1 to 1 to 1 to 1 to		20a. Method of Disposition 1 🕱 Burial 2 □ Cremation 3 □ Removal fr	20b. Place of Dispo			. Location - City or To	wn, State
Ĕ	permit. Pages Department of I Importent: if it any injury or o		4 ☐ Donation 5 ☐ Other (Specify)	Garrison	Forest Vet. 1	/13/06 0	wings Mi	lls, Md
Ba	Depa Impo any ii		21. Signature of Juneral Service Licensee	Malland Ma	arch F/H West 300 Wabash Ave,	Baltimo	re, Md	21215
4	Dhaaisiaa		25a. Part1. Enter the disease, or compfications the shock, or heart failure. List only one cause of Immediate Cause (Final	at caused the death. Do not ent on each line.	er the mode of dying, such as cardiac			Approximate fnterval Between Onset and Death
)	Physician /Medical Examiner		disease or condition resulting in death)	to (or as a consequence of):	monia			
		ner	Sequentially fist conditions, it is any leading to immediate cause. Enter Underlying	to (or as a cons∌ uence of):				
760,	le be executed ysicien and e burial-transit	cal Examiner	Cause (Disease or injury that initiated events resulting in death) Last	to (or as a consequence of):				
89	~ ~ w		d					
P.O. Box	The law requires that the death certificat, site has been signed by the attending phy age 2 should be detached for use as the	Physician/Med	23b. Was decedent pregnant 1 Linking the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delive Month	ny Day Year
	w requires that the stand of the signed by should be detact	ğ	Part II. Other significant conditions contributing	o death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobace	co use contribute to the	
Division of Vital Records,	The law re cate has being page 2 sho	Completed				24a. Was an autopsy performed 1 Tyes 2	death?	psy findings available inpletion of cause of
Vita	Physician: r this certificatal director,	9 Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	☐ Impatient 2 ☐ ER/Outpatier	Other	th Check only one	- 0 FlOsher /04	
ion of	I or Attanding Physician: The lavarier death. Director: After this certificate has	ation: To		ate of fnjury Nonth, Day Year) 28b. Time o		28d. Describe how i	a 6 □Other (Specify njury occurred	0
Divis	el or Atta s after des i Director d in by th	Certification:	3 Suicide 6 Could not be determined 28e. P	lace of fnury - At home, farm, sti uilding, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rura tate)	l Route Number,
	To the Hospitel or Att within 24 hours after of To the Funerel Direct completely filled in by	edicai	(Check only 2 Medical Examiner: On the one)	ie basis of examination and/or in nanner stated.	h occurred at the time, date and place evestigation, in my opinion, death occu	rred at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
	To t withi To t	M	29b. Signature and title of certifier	Sall, My)	29c. License number D052950	29d.	Date signed (Month,	
	A		30. Name and address of person who completed	cause of death (Item 23a) (Type,	V. Buttimore	St	1	
6 · · · · · · · · · · · · · · · · · · ·	Sta Regist	ate rar	30. Name and address of person who completed a Hond math, Mil 31. Date filed (Month, Day, Year) JAN 1 8 2006	Registrar's Signature	de			

			For State Registrar	State of Marylar		artment of rtificate of			giene 06	00876	
	Physici /Medio	al	1. Decedent's Name (First, Middle, Last)	all				2. Date of Dea Month Januar	Day Year	06 20:30M	
S. S. S. S. S. S. S. S. S. S. S. S. S. S	Examin Funeral	er	5. Social Security Number 6. Sex	maryland 7. Age (In yrs.		Baltic If Under 1 Year Months Days	ff Under 24 Hr	City s. 8. Date of Birth	4c. County of De	ath irthplace (State or Foreign	
	Director		217 -80 - 259 5 Usual Residence of Decedent 10a. State 10b. County	₹M 2□F 43	Yrs. ty, Town or Lo		110010	March 7	, 1962	MD 10d. Inside City Limits	
	h the Mary or 26a-1 she or colline	irector	MD 10e. Street and Number	В	<u>ALTIMOI</u>	RE 10f. Zip Code			10g. Citizen of What (1 ∏Yes 2 ☐ No Country?	
9	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Machael Exeminar must be indified at	Funeral Director	841 LENNOX ST 11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1 Yes M No			Hispanic Origin? (pan, Mexican, Pue	1217 Specify Yes or No- into Rican, etc.)	14. Race - An Black, Wh	USA 14. Race - American Indian, Black, White, etc.	
21215-0036	within 72 hours ene. than "natural", i	Completed by	3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grade) Elementary/Secondary (0·12)		16a. Dece	1 Yes 2 No dent's Usual Occu kind of work done DO NOT use retire	pation during most of w	orking	SpecifyBLA		
	id be filed wit ental Hygiene ked other tha ic event, the	Be	12 17. Father's Name (First, Middle, Last) WALTER J. HALL		NEWS	PAPER DI		R ame (First, Middle, ITA PHILL	· ·	SUNPAPER	
, Maryland	and 2 should raith and Mer 27 is marke ar traumatic	٦	19a. Informant's Name/Relationship (Ty LENORE GARY/SIST)	ER		841 LEN	t and Number or F		r, City or Town, State,	Zip Code)	
Baltimore,	permit. Pages 1 Department of He Important: If Iter any Injury or oth		20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature 1 Funeral Service License	Removal from State	1 + C		oss of Facility J		BALTIMORE ORTON & SO	E, MD	
36			23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final	ications that caused the deathe cause on each line.						Approximate Interval Between Onset and Death	
Physician // Medica Examine physician and physician and physician and the prulai-transit		licai Examiner	disease or condition resulting in death) Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect	Anex Juence of):	s nia nutri	teon			Chrenic Chrenic	
P.O. Box 6	death certific a attending p od for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	33c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of conditions of the second of th	al death 3□	Ectopic pregnand Other (specify)	су		23d. Date of di Month	elivery Day Year	
	law requires that the es been signed by th 2 should be detache	by	Part II. Other significant conditions cor	ntributing to death but not res	sulting in the u	nderlying cause g	ven in Part I.			to the cause of death? Probably 4 Punknown	
tal Rec	The la ate hes page 2	e Completed	25. Was case referred to medical						sy prior to med? death? 2 ☑ No 1 ☐ Ye	autopsy findings available completion of cause of us 2 No	
of Vil	S	To B	examiner?	Hospitaf: 1 ☐ Inpatient 2 2	ER/Outpatier	" 30 DOX	her: 4 \(\text{Nursing}		ence 6 Other (Sp ow injury occurred	ecify)	
Division of Vital Records,	To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral	Certification;	1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	(Month, Day Year) 28e. Place of Injury - At h building, etc. (Special Control of the Control of	Injury ome, farm, str	M 1	Yes 2 No		treet and Number or F	Rural Route Number,	
	Hospital (24 hours at Funeral Distely filled i	edical Ce	29a. Certifier 1 Certifying Physical Exemination (Check only one)	sician: To the best of my kno ner: On the basis of examina	owledge, death	n occurred at the t	ime, date and plac	ce, and due to the courred at the time, d	ause(s) and manner a	as stated.	
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stated.							
-			30. Name and address of person who co	om Neleted cause of death (Iter ST, HELE NA 32/Registrar's Signa	n 23a) (Type,	Print)	7202		1/17/0	06	
	Sta	te	S.S. DANG M.D. 101 31. Date filed (Month, Day, Year)	ST. HELENA	A Vi	E BA	LTIMO	RE M	1. 2-12	222	
100	Registr		JAN 1 8 200	06 Allers A	1 Age						

			For State Registrar		State o	of Maryla		artment of H rtificate of L		Mental Hy	/giene () Reg. No.	06	00877
П	Physici	an	1. Decedent's Name	(First, Middle, La	st)					2. Date of D Month	eath Day	Year	3. Time of Death
	/Medic				Augu		ward H	isker		Janua	ry 15,	2006	6:29 A M
	Examin	er	4a. Facility Name (If n			imber)		4b. City, Town, or		h		nty of Death	
			5. Social Security Nur	nstern A		7 Age (In vr	s. last birthday)	Esse:	X If Under 24 Hrs.	8. Date of B	Balt	imore	County place (State or Foreign
	Funeral Director		214-44-79		X M 2□F	6		Months Days	Hours Min.	(Month, D	ay. Year) 16,1945	Cou	vland
	ט		Usual Residence of D							Hugust	,154) Hai	y tailo
	anylar show	_		10b. County		10c. C	City, Town or Lo	cation					10d. Inside City Limits
	Ba-f	Directo	Maryland	Baltim	ore			Esse	ex				1 ☐ Yes 2 🛣 No
	with t		10e. Street and Numb		Eastern	R1 vd		10f. Zip Code	21220		10g. Citizen		intry?
	eath	erai	11. Marital Status	1730		edent Ever in	U.S. 13.	Was Decedent of Hi		necify Yes or N		S.A. Race - Ameri	ican Indian
36	be filed within 72 hours after death with the Maryland ital Hygiene. od other than "natural", or iteme 23a or 28a-f ehow event, the Modical Exacilizar most be notified at	by Funerai	1 ☐ Never Married		Armed Fo 1 ☐ Yes If Yes, Gi Year or D	orces? 2∭ No ive		Was Decedent of Hi II Yes, specify Cubai 1 □ Yes 🛣 No	n, Mexican, Puerl Specify:	o Rican, etc.)	Spe	Black, White,	, etc.
8	tural	edt		5. Decedent's E		7a(6 3.	16a, Dece	dent's Usual Occupa	ation		16b. Kind of		ite
15	n "ns	Completed	(Specify	only highest gra	de completed) College ((Give	kind of work done d DO NOT use retired,	luring most of wor)	rking	TOD. TUNG OF	D03111033411	laddity
212	e filed within at Hygiene. other than "	E O	8	Jaily (0-12)	College (1-401 5+)		Labor	er		Const	ructio	on
ק	be filed tal Hygi d other event, II	Bec	17. Father's Name (F.	irst, Middle, Last,)				18. Mother's Nar	ne (First, Middle	e, Maiden Sum	ame)	
<u>yla</u> ı	should be nd Mental marked (70			Cliffo	rd His	rer		Eliza	beth Ep	erson		
Maryland 21215-0036	C/ 42 = 5		19a. Informant's Nam				19b. Maili	ng Address (Street a	and Number or Ru	ıral Route Numi	ber, City or Tov	vn, State, Zi,	p Code)
	s 1 and of Health Item 27 other to		Mrs. Renee		Daughte			ewParkRoad	d NewPa	rk, Penn Date	-		
20	8°= 5		20a. Method of Dispo	Cremation 3		State	cemetery, crei	natory or other place	1		20c. Locatio	n - City or i	own, State
Baltimore,	교투원급 .		4 □Donation 5			Ho:		MemorialG	4 = 10	12/11/2017			aryland
Ba	Depa Impo eny		mucho	ul Pm	arull		60	09 Harfor	ma d Road	rzullo Baltimo	re, Marv		
			23a. Part1. Enter the shock, or heart	disease, or com failure. List only	plications that one cayse on e	caused the de each line.	ath. Do not en	er the mode of dying	g, such as cardiad	or respiratory	arrest,		Approximate Interval Between Onset and Death
1	Physician		Immediate Cause (Fi disease or condition resulting in death)	inal	a Jine	ske.	Para	dion o	nd 1/0	rmelI	Niu,	4	Onset and Death
	/Medical Examiner		resulting in death)	(Due to	(or as a conse	equence of):				,		
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á	licate be executed physicien and s the burial-transit	Еха	resulting in death) La	st	CDue to	(or as a conse	equence of):						
38760,	ite be iysicie ne bu	d											
_			IF FEMALE:										
.O. Box	et the death certif by the attending tached for use a	Physician/M	23b. Was decedent print the past 12 mm 1 Yes 2	onths?		birth 2 □ Fe nantattime of	tal death 3	Ectopic pregnancy Other (specify)				Date of deliv Month	rery Day Year
ď.	requires thet leen signed b hould be deta	by P	Part II. Other signific	ant conditions	contributing to d	leath but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco use co	ontribute to t	the cause of death?
ğ	w require been sig should b									1 🗆	Yes 2□No	3 ☐ Prol	bably 4 Unknown
Vital Records,	law as b 2 s	Completed								24a. Was	s an 24	b. Were auto	opsy lindings available
Œ	The ate h page	E O									ormed? 2 ☐ No	death?	2 □ No
/ita	ysiclan: Th is certificate director, pag	Be (25. Was case referre examiner?	d to medical					26. Place of Dea	ath (Check only	one)		
5	Physiclan: this certific ral director,	2	1 Xes 2 N	0			☐ ER/Outpatier		4 🗀 Nursing F	lome 5□Res		ther (Special	^{fy)} Scene
N C	After Funer	ertification:	27. Manner of Death 1 ☐ Natural	5 Pending		of Injury oth, Day Year)	28b. Time o	Work		28d. Describe	how injury acc	urred	لذ، ي
Division	Attending r death. ector: After by the fune	cat	2 Accident 3 ☐ Suicide	investigation	1110	a of Injury a At	home farm st	M 1 ☐ Y	res 2 No	281 Location	(Street and Nu	Sed Ve	effecte al Route Number.
Ω	aftar Dire	ertii	4 Homicide	determined	build	ing, etc. (Soe	AR LO	T		City or To	wn, State)	A	21221
	To the Hoepital or Attending I within 24 hours after death. To the Funeral Director: Atter complataly filled in by the funer	Medicai C	29a. Certifier 1 (Check only 2	Certifying Ph	niner: On the b	pasis of examin	nowledge, deat nation and/or in	n occurred at the tim vestigation, in my op	ne, date and place pinion, death occu	, and due to the	cause(s) and , date and plac	manner as se, and due t	stated. o the cause(s)
	within 2 Within 2 To the compla	Mec	29b. Signature and til	tle of certifier	anuman	nner stated.		29c. License	number		29d. Date sig	ned (Month.	Day, Year)
	⊢ s ⊢ ŏ) / /	LA.	IMAA	1		OCM.	īr				
•	1		30. Name and address	ss of person who	completed cau	se of death (It	em 23a) (Type.	OCM Print)	1.		Januar	у 16,	2006
_	1		JUARe		let u			111 Penn	Street	Baltimo	re, Mar	yland	21201
	Sta		31. Date filed (Month	, Day, Year)	32.	egistrar's Sig	nature						
4	Regist	ar		N 1 8 20	006	ALHA)	N. A						

			1 - State Registrar		Cei	tificate of	Death	Mental Hygi	g. No.	00070
	Physici /Medic		Decedent's Name (First, Middle, Last) Marie Henry						Day Year 8 2006	1:30 AM M
)	Examin	er	4a. Facility Name (If not institution, give s 700 W. 40th St 5. Social Security Number 6. Sex	reet		4b. City, Town, o	timore		4c. County of Dea	
	Funeral Director			/. Age	78 Yrs.	Months Days	Hours Mir			rthplace (State or Foreigi Jountry) nsylvania
the Maryland	r 28a-f show notified at	rector	10a. State 10b. County MD 10e. Street and Number		10c. City, Town or Lo	imore		og. Citizen of What C	10d. Inside City Limits 1 Yes 2 No	
-UUSO hours after death with	permit. Pages 1 and 2 should be liled within 72 hours after death with the maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. By injury or other traumatic event, the Medical Evantral must be notified at once.	ed by Funeral Director	700 W. 40th Stree 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	21211 Was Decedent of Hispanic Origin? (Specify Yes or Note of Hispanic Origin? (Specify Yes or Note of Hispanic Origin?) 1 ☐ Yes 2 ☑ No Specify:			USA		
Maryland 21215-0036 d2 should be filed within 72 hours at	al Hygiene. I other than "na vent, the Medic	Be Completed	(Specify only highest grade Elementary/Secondary (0·12) 12 17. Father's Name (First, Middle, Last)	kind of work done DO NOT use retired instruct	during most of w d) Ox		ial security adm on Sumame)			
Mar	ealth and Ments m 27 is marked ser traumatic es	ToB	Nicholas Ernades 19a. Informant's Name/Relationship (Ty) Patricia Kerler/d		123	W. 29th	and Number or F	altimore,		3
Baltimore, permit. Pages 1 ar	permit. Pages 1 a Department of He Important: If iten any injury or oth once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R '4 ▼ Donation 5 □ Other (Specify) 21. Signatu Funeral Service License 1 □ 1 □ S • W	e /	25	natory or other place	es of Facility		Baltimore	
PI E	nysician /Medical xaminer	Examiner	23a. Part 1. Enter the disease, or complishock, otheart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as:	the death. Do not ent	altimore, er the mode of dyin			st,	Approximate Interval Between Onset and Death McLV
I Records, P.O. Box 68/60, The law requires that the death certificate be executed	igned by the attending physicia be detached for use as the bur	Completed by Physiclan/Medical	in the past 12 months? 1 Yes 2 PNo 9 Unknown	4☐Pregnant at 9☐Unknown	2 Fetal death 3 time of death 5	Ectopic pregnancy Other (specify)		220 Did tob	23d. Date of de Month	Day Year
Records, be law requires th	as been signe. 2 should be d	pleted by	Pag II. Other significant conditions con	tributing to death bi	ut not resulting in the u	nderlying cause giv	en in Part I.	1 ☐ Ye	s 2 No 3 P	o the cause of death? robably 4 Unknown utopsy findings available completion of cause of
Vital H	ertificate h actor, page	Be	25. Was case referred to medical examiner?				4 2	perform	death? □ No 1 Yes	s 2 No
UIVISION OF VITA To the Hospital or Attending Physician:	within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification; To	27. Man of Death 1 Natural 5 Pending 2 Accident investigation	lospital: 1 Inpatie 28a. Date of Injui (Month, Day		28c. Injur Wor	4 Mursing	Home 5 Resider	nce 6 Other (Spe w injury occurred	ecify)
DIVIS	ours after de eral Direct filled in by t		4 Homicide determined	building, etc	ury - At home, farm, str c. (Specify) of my knowledge, deatl		no date and place	City or Town		
To the Hos	within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	(check only one) 2 Medical Examin 29b. Signature and title of certifier	ner: On the basis of and manner sta	examination and/or in	vestigation, in my o	pinion, death occ	curred at the time, da	te and place, and du	e to the cause(s)
	Sta		30. Name and address of person who co	ruc 6	eath (Item 23a) (Type,	Print) (HOWE)	ST B	MIMORE	d. Date signed (Mon Jun 09, 20 MD	21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year STEFAN J. JACHEM JAN. 9:20 A M 15 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7630 GOUGH STREET BALTIMORE N/A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 ☐ F Director 216-12-0899 82 Yrs SEPT. 6. 1923 MD. Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other then "naturel", or Items 23a or 28e-f show treumstic event, the Medical Exercities at Be Completed by Funeral Director 1 ☐ Yes 2 📆 No MD. COLGATE N/A 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with it. Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "nature" any injury or other treumatic average. 10g. Citizen of What Country? 7630 GOUGH STREET 21224 UNITED STATES 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 💥 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: 3 ♥ Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry BALTIMORE CITY Elementary/Secondary (0-12) College (1-4or 5+) SUPERVISOR 6TH FILTRATION PLANT 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) STANLEY JACHEM 2 KAROLINA MAJKA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SUSAN RICE/DAUGHTER 7700 GOUGH ST., BALTIMORE, MARYLAND 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State OAK LAWN CEMETERY * 4 ☐ Donation 5 ☐ Other (Specify) 1/18/2006 BALTIMORE, MARYLAND 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 21. Signature of Funeral Service Licensee 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final C disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Box 68760. To Be Completed by Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 ☐ Other (specify) P.0. the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 Probably 4 Sunknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 performed' 1 Yes 2 🗆 🗸 o Division of Vital othe Hospitel or Attending Physicien: director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one 1 ☐ Yes 2 ☐ Yo Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 405 PICE 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Medical Certification: After 1 Natural
2 Accident 5 Pending within 24 hours after death. To the Funerel Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 2st. Carther Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Po Henrice at MID

TAH, MD.

30. Name and andress of person who completed cause of death (Item 23a) (Type, Print)

KENWOOD AVE, BAJO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiere 1 1 6 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** atril, a 1644216 2 20 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 24 Hrs. wh Mesk 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🛣 F 578-36-8490 Yrs Director 79 7,1926 Pennsylvania Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location and Mental Hygiene. Is marked other than "natural" or Items 23e or 28a-f show raumatic event, the Medical Examinar must be inclifted at 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Baltimore Baltimore Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1632 Forest Park Avenue 21207 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Aide Science 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret Pollock 2 C. LeRoy Reeder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Lori Ann Jensen Daughter 7261 Eden Brook Drive Apt 203: Columbia, MD 21046 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 20c. Location - City or Town, State permit. Pages I Depertment of H Importent: If ite eny injury or ot ance. 1 ☐ Burial 2 【ICremation 3 ☐ Removal from State Metro Crematory 1/12/2006 4 ☐ Donation 5 ☐ Other (Specify) Catonsville, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Licenses Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Chil STA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, ettending physicien Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Dunknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed this certificate 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1. Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: At completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 THomscide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mr thraset 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

	1	For State Registrar 1. Decedent's Name (First, Middle, La	State of Maryla		artment of Hortificate of L	Death		ne 06	0 0 8 8 1
Physicia /Medica Examine	al er	Irma Mae Jones 4a. Facility Name (If not institution, gin Baltimore Wahing	re street and number) ton Medical Co		4b. City, Town, or Glen Bur	Location of Death	- Month January	Day Yea 17 200 4c. County of De Anne Aru	b 6555 A'
Funeral Director			. C. 11 . C. C.	rs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	B. Date of Birth (Month, Day,) uly 8,	1925 9. B	irthplace (State or Foreig Country) VA
ath with the Maryland \$ 23a or 28a-f show	ector	MD Anne Ar		City, Town or Lo asadena					10d. Inside City Limit
ath with u	Funeral Director	10e. Street and Number 163 Mountain Rd			10f. Zip Code 21122			USA	L
ors a	Ď	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 □ Yes 发斑 No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ☎ No	spanic Origin? (Spec h, Mexican, Puerto R Specify:	ican, etc.)	Black, WI	nencan Indian, nite, etc. Thite
_ 200	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired) Lcian Alde	uring most of workin	g 16	6b. Kind of Busines Hospita	
d oth	To Be Co	17. Father's Name (First, Middle, Las Dallas Stanley	")	18. Mother's Name Eva	(First, Middle, Ma				
50.4		19a. Informant's Name/Relationship Eva Marie Sumner			ng Address (Street a Christos (
Depertment of Heal Important: if item 2 any injury or other once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 [4 □ Donation 5 □ Other (Spec	Removal from State	cemetery, cre	osition (Name of matory or other place en Cemeter		_	oc. Location - City Len Burni	
Depertu Importa any inju once.		21. Signat John Tuneral Service Lice	No.	1.06.7	lame and Addres Ink Funer 426 Crain			mnia MD	21061
te be executed ysician and le burial-transit	dical Examiner	23a. Part1. Enter the disease, or conshock, wheat failure—List on immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cons Due to (or as a cons Due to (or as a cons d.	sequence of):	ter the mode of dying	, such as cardiac or	respiratory arres	it,	Approximate Interval Between Onset and Teath
it the death certificate by the ettending phy: tached for use as the	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre- 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of c Month	delivery Day Year
		Part II. Other significant conditions	contributing to death but not	resulting in the u	inderlying cause give	n in Part I.			to the cause of death?
ine law requires trat free cate has been signed by the page 2 should be detached.	Completed						24a. Was an autopsy perform	prior t	autopsy findings availat o completion of cause of ? es 2000
is cer direct	o Be	25. Was case referred to medical examiner? 1 Tyes 2 100	Hospital: 1 Inpatient 2	P ☐ ER/Outpatie	nt 3 DOA Othe	26. Place of Death) ice 6 ☐Other (Si	pecify)
To the Hospitel or Attending Phyminic 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical Certification: T	27. Many of Death 1	be One Oless of Jaiway A	at home, farm, si	M 1 🗆 Y	? /es 2 \(\text{No} \)	8d. Describe how 8f. Location (Stre City or Town,	et and Number or	Rural Route Number,
ne nospitet n 24 hours a he Funeral I	edical C	29a. Certifier (Check only one) 1 Certifying F	hysician: To the best of my miner: On the basis of examiner shall d.	knowledge, dea nination and/or II	th occurred at the tim	e, date and place, a pinion, death occurre	nd due to the cau d at the time, dat	use(s) and manner te and place, and d	as stated. lue to the cause(s)
To the within 2 To the Complei	Σ	29b. Signature and title of certifier	T Sil	& ms	29c. License	-0094	29	d. Date signed (Mo	100
b		30. Name and address of person	completed cause of death (Item 23a) (Type	ladion_	Pon A	K On	ir da	Bring ind 2

DHMH 17 Rev 1/2001

ORIGINAL

		4	For State Registrar	State of Marylan		artmen rtificat			ind M		giene Reg. No.	006	00882	
V X	4.		Decedent's Name (First, Middle, Last)							2. Date of Dea	ath	V	3. Time of Death	
	Physicia /Medic		Millie Ann Kit	trell							Day	2006	2:25PM	
	Examin		4a. Facility Name (If not institution, give st			4b. City,		Location of			4c.	County of De	ath	
	À	e)	3615 Lucille Av			If I lado	Ba]	Ltimo				N/A		
	Funeral Director		5. Social Security Number 6. Sex 1 1	7. Age (In yrs.	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da	y, Year)		irthplace (State or Foreign Country)	
9.5			Usual Residence of Decedent	74						June	21,	1931	W.Virginia	
	how		10a. State 10b. County	10c. Cit	ty, Town or Lo	ocation							10d. Inside City Limits	
:	89-1-	cto	Maryland N/A		Bal	timore							1⊠Yes 2 No	
	Nor 2	5	10e. Street and Number 3615 Lucille Ave			10f. Zip	Code	_				zen of What (Country?	
:	be lied within 72 hours effer death with fine Maryland hal Hygiene. Hygiene do ther then "natural", or iteme 23a or 28e-f ehow event, the Medical Examinar must be notified at	Funeral Director		2. Was Decedent Ever in U	S 13				in? (Soe	ofy Yes or No	USA		nerican Indian.	
	riten	돌	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 € No		If Yes, spe	cify Cuba	n, Mexican,	, Puerto F	Rican, etc.)		Black, Wi	nite, etc.	
2-003g	raf', o	ğ	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 🗌 Yes	20 No	Specify:				Specify: B	Lack	
ה ה	within 72 hours effer ene. then "natural", or ite	Completed	15. Decedent's Educa (Specify only highest grade	ation completed)	16a. Dece (Give	kind of wo	rk done c	furina most	of working	g	16b. Ki	nd of Busines	s/Industry	
7	within then then then then then then then the	g	Elementary/Secondary (0-12)	Cottege (1-4or 5+)		DO NOT u					Priv	ate I	Homes	
	e filed within al Hygiene. other then vent, ILE Me	မ ငိ	12th grade 17. Father's Name (First, Middle, Last)		Dome	STIC	Enc	ginee		(First, Middle,	Maiden	Sumame)		
and		To Be	Louis Millner					Bess				,		
ary	ges 1 and 2 should be 1 to 1 Health and Mental be 1 if itam 27 le marked of or other traumatic eve		19a. Informant's Name/Relationship (Type	e, Print)	19b. Maili	ng Address	(Street a	and Numbe	r or Rura	Route Numbe	e Number, City or Town, State, Zip Code)			
Z :	alth a alth a 27 le		Lizzie Monroe/ I	Daughter	4012	Wood	lmer	e Ave	e Ba	ltimo:	re,	Md 21	215	
e G	of Hea of Hea fitam r othe	ı	20a. Method of Disposition 1∑ Burial 2 □ Cremation 3 □ Re	moval from State	Place of Dispo cemetery, cre	matory`or o	ther plac	e)1	1/18	06		_	or Town, State	
Ĕ	Pag ment ant: I ury o		4 Donation 5 Other (Specify)	Ca	rroll	Men	oria	al Ga	ar.,	Inc.	Fir	ıksbuı	g,Maryland	
Baltimor	permit. Pages Department of b Important: If its eny injury or of QDCB.		21. Signature of Funetal Service Licensed	9									neral Home ,Md 21215	
Ú	W Top		23a. P. 11. Enter the disease, or complice shock, of heart failure. List only one	ations that caused the deat cause on each line.	th. Do not en	ter the mod	de of dyin	g, such as o	cardiac o	respiratory ai	rest,	_	Approximate Intervat Between	
8	Physician	+	Immediate Cause (Final disease or condition	Caro	lio n	WH	afte	û					Onset and Death	
89	/Medical Examiner		resulting in death)	Due to (or as a conseq	quence of):	11		1						
	Exammer	_	Sequentially list conditions, b.	Dua to for as a nonsec		9 1		·						
7	usit	nine	Tany, leading to him ediats cause. Enter Underlying Cause (Disease or injury	Dua to (or se a noneco	(iiianina ori).									
V	be executed icien and burial-transit	Examin	that initiated events c. resulting in death) Last Due to (or as a consequence of):											
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ğ	death certificate e attending physical d for use es the	ledi											1	
ROX	leath certific attending p	Physician/Me	230. Was decedent pregnant	c. If yes, outcome of pregna 1 Live birth 2 Peta	ancy aldeath 3	∃Ectopic p	rennancy				1	23d. Date of c	•	
		sici	in the past 12 months? 1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \)	4☐Pregnant at time of c 9☐Unknown		Other (s						Month	Day Year	
r Ö	res that the de igned by the a be detached f	Phy	9 ☐ Unknown Part II. Other significant conditions cont	abuting to death but not re-	culting in the c	adorhina i		on in Part I		23a Did t	obacca u	co contributo	to the cause of death?	
က်	requires that the neen signed by th hould be detache	ρ	Diahetes	Mellitis	sulting in the c	maenying i	ause give	en in Fan i.			Yes 2		Probably 4 Dunknown	
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		e Co	25. Was case referred to medicat					GE Place	of Dooth	1 Yes		1 🗆 Y	es 2 No	
	Physiclen: r this certific ral director,	To B	examiner?	ospital:] ER/Outpatie	nt 3 🗆 D	OA Oth			ne 5 Resid		5 □Other (St	necify)	
<u>_</u>	ding Phy h. After thi funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o		28c. İnjun Worl			8d. Describe I			,,	
<u>S</u>	uttendin death. ctor: Af y the fu	atic	2 Accident investigation			М	1 🗆	Yes 2 □ h	No					
Division of	T P T C	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specia	iome, farm, st	reet, factor	y, office		2	8f. Location (3 City or Tox			Rural Route Number,	
2	oital o													
	Hosp 24 ho Fune Fune	Medical	29a. Certifier (Check only one) 1 Certifying Phys. 2 Medical Exemin	icien: To the best of my known and manner stated.	owledge, dea ation and/or ir	th occurred ivestigation	l at the tin n, in my o	ne, date and pinion, deat	d place, a th occurre	nd due to the od at the time,	cause(s) date and	and manner I place, and d	as stated. ue to the cause(s)	
	To the Hospital of within 24 hours at To the Funerel D completely filled is	Mec	29b. Signature and title of certifier	and manner stated.		29	c. License	e number			29d. Dat	e signed (Mo	nth, Day, Year)	
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	1		30. Name and address of person who cor	ne eted cause of death (Ite	m 23a) (Type	, Print)	. γΨ	- 1	2-0.	• 1	C =		Baltimore XX	
			Cheryl A.C	Jackson,	ms	2	435	WI	sew	eoure	AR	, #24,	Boltimore X4	
	Sta Registi		31. Date filed (Month, Day, Year)	J 32. Registrar's Sign.	ature	50 1.0								

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 6 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 13, James P. Keating, Jr. 2006 P M January 8:53 /Medical 4a. Facility Neme (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Rockville Nursing Home Montgomery Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (Standard) September 2, 1927 Michigan Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**X** M 2□ F 578-30-6441 78 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r then "natural", or Items 23a or 28a-f show the Wedical Exchipter, must be notified at 1 ☐ Yes 2X No Maryland Montgomery Bethesda Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9907 Mayfield Drive 20817 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WWII 1 ☐ Yes 2X No Specify: þ Specify: White 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0wner Restaurant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill iment of Health and Mental H tant: If Item 27 is marked off James P. Keating Ida Ford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9907 Mayfield Drive, Bethesda, Maryland 20817 Marjorie C. Keating / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State January 1 Burial 2 Cremation 3 Removal from State ₩ 0 permit. Page Department of Important: if any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 18, 2006 Silver Spring, Maryland 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. Mugulatta Barris M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death tmmediate Cause (Final **Physician** Respiratory Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Restrictive Lung Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-tran signed by the attending physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be Left Hip Fracture 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate 1 ☐ Yes 1 ☐ Yes 2X No or Attending Physician: 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Inpatient examiner: 1 X Yes 2 ∏ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Diractor: After th
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 □Natural 5 Pending investigation Nov. 6, 2005 unknown 1 Yes 2 X No Fall 2 X Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 9907 Mayfield Dr., Bethesda, MD. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) loms/20 D51916 January 13, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11119 Rockville Pike, G-100, Rockville, Maryland 20852 Patricia Tomsko Nay, 31. Date filed (Month, Day, Year) 32. Degistrar's Signature State Registrar 8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Year Reba S. Kelly 10:18 a. M January 15, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner **Baltimore Baltimore City** Gilchrist Hospice Center If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Director Yrs 81 237-22-1612 September 27, 1924 North Carolina Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location in then "natural", or items 23a or 28e-f eho 1 ☐ Yes 2 No by Funeral Director Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21042 U.S.A 3453 Tyler Dr. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Yes 21 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry U.S. Postal Service Elementary/Secondary (0-12) College (1-4or 5+) Clerk unk or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be **Ernest Clifton Stokes** Nancy Elizabeth Jones 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Heelth as Important: if Itam 27 is eny injury or other traugone. 3453 Tyler Dr. Ellicott City, Maryland 21042 Ms. Nancy Kelly Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Domation 5 □ Other (Specify) 01/19/2006 Marriottsville, Maryland Crest Lawn Memorial Gardens 21. Sonature of Fugeral Service Licen 22. Name and Address of Facility Muskeller Slack Funeral Home, P.A 10025 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician END STAGE /Medical Due to (or as a consequence of): Examiner DIOPATHIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ettending physiclen and tor use as the burial-transit Due to (or as a consequence of): Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes ☐ No 23d. Date of delivery 3 □Ectopic pregnancy Month Day Year 4□Pregnant at time of death ned by the el 5 Other (specify) 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 Probably 4 Unknown 1 Tyes 2 No Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 5 KN0 Hospital: Other: 4 Nursing Home 5 Residence 1 Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA exother (Specify) HOSDI CO 27. Manner of Death 1 Death 2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed o. ۵. of Vital Records, Division

Box 68760,

certificate To the Hospital or Attending Physician: within 24 hours efter death.

To the Funerel Director: After this certifica completely tilled in by the tuneral director, p s effer dec. rej Director: Afr

has

or 28e-f show

tited within 72 hours after death

and Mental

Pages 1 and 2 should be

Baltimore, Maryland 21215-0036

2564 death (Item 23a) (Type, Print) Street llene MD 6601

State Registrar

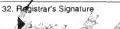
Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

JAN 1 8 2006



and manner stated.

Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

AEM 06-00293 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a,PII,27,28a f, pent ,6331,124 black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Ernest Lee II Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Month Year ERNEST LEE II 12 2006 /Medical January 9:00 A 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1016 Mount Holly Street Baltimore City n/a If Under 1 8. Date of Birth (Month, Day, Year) 04/22/1961 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours XXM 2□F 44 216-78-6197 Yrs MARYLAND Director Usual Residence of Decedent Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f ehow the Madical Examiner must be nutified at 14 Yes 2 □ No BALTIMORE CITY Director MD N/A the 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 1016 MT. HOLLY STREET USA 238 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status US within 72 hours after 1 XNever Married 2 ☐ Married 1 X Yes 2 □ No If Yes, Give Year or Dates: 5 Maryland 21215-0036 BLACK AIR 1 ☐ Yes XXNo Specify: δ 3 ☐ Widowed 4 ☐ Divorced "nature!" FORCE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) YEARS ACCOUNTANT US GOVERNMENT 12TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame nd Mental h 90 FLORENCE THORN ERNEST LEE SR. Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, partment of Health a cortaint; if item 27 is 1016 MT. HOLLY ST., BALTIMORE, MD 21229 FLORENCE LEE / MOTHER Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriai 2 XCremation 3 ☐ Removal from State METRO CREMATORY 01/17/06 CATONSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses permit. Depart Import any inj 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEICHTS AVE., BALTIMORE, MD 4 1) Enter the risease, or complications that caused the 198 th. Do not enter the mode of dying, such as cardiac or respiratory arrest, or hear ailure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a. Cocaine Intoxication /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physicien and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, been sig 3 Probably 4 XUnknown Atherosclerotic Cardiovascular Disease 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a. Was an certificate has b irector, page 2 sl autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Xes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA this After this 28a. Date of Injury Fnd | 28b. Time of | Unk | 28c. Injury at | Work? 27. Manner of Death Certification: 28d. Describe how injury occurred unk s after dea. 1 Natural 5 Pending 1 ☐ Yes 2 No investigation 1/12/06 2 Accident 6X Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1016 Mount Holly St. 4 | Homicide Baltimore, MD within 24 hours a To the Funeral C completely filled Found at residence 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) how MIN OCME January 13, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

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JAN 1 8 2006

31. Date filed (Month, Day, Year)

miD

32. Registrar's Signature

Booker

111 Penn St. Baltimore, Maryland 21201

			State of Maryland / [Department of Health and Mental Hygiene 06 0886 Certificate of Death Reg. No.
	Physici /Medi		Decedent's Name (First, Middle, Last) HUGH LEE LONG	2. Date of Death Month Day Year January 1, 2006 11:40 p ^M
1	Examir	ner	4a. Facility Name (If not institution, give street and number) Charlotte Hall Veteran's Home	4b. City, Town, or Location of Death Charlotte Hall St. Mary's
	Funeral Director		204-01-2329	hday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Yrs. Months Days Hours Min. July 20, 1921 Georgia
re, Maryland 21215-0036	w requires that the death certificate be executed by the executed be seed to	To Be Completed by Funeral Director	10e. Street and Number 4226 29th Street 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 17. Father's Name (First, Middle, Last) Hugh Spencer Long 19a. Informant's Name/Relationship (Type, Print) Dorothy M. Long — Wife 20a. Method of Disposition 12. Was Decedent Ever in U.S. Ammed Forces? 1 Name Forces?	Rainier 10f. Zip Code 20712 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) 16b. Kind of Business/Industry 16b. Kind of Business/Industry 16b. Kind of Business/Industry 16c. Kind of Business/Industry 17c. Maiden Sumame) Eva Lee Knight Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 226 29th Street, Mount Rainier, Maryland 20712 Disposition (Name of Date 20c. Location - City or Town, State)
		Examiner	2 Defenation 3 Demoval from State	Hill Cemetery 1/5/2006 Suitland, Maryland 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781 ot enter the mode of dying, such as cardiac or respiratory arrest. entia Pears Onset and Death Years Disease Weeks
rds, P.O. Box 68760,		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3 Ectopic pregnancy 5 Other (specify) the underlying cause given in Part I. 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death?
l Rec	n: The law req licate has beer r, page 2 shou	Completed by		24a. Was an autopsy performed? death? 1 Yes 2 No 1 Yes 2 No
vision	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification: To Be		ime of injury at Work? M 28c. Injury at Work? 1 Yes 2 No
		Medical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge 2 Medical Exeminer: On the basis of Amination an and manner stated. 29b. Signature and title of certifier	death occurred at the time, date and place, and due to the cause(s) and manner as stated. for investigation, imply opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) D45092 January 6, 2006
DHM	Sta Registi MH 17 Rev 1/2	rar	31. Date filed (Month, Day, Year) JAN 1 8 2006 32. Registrar's Signature	Type. Print) spital Road #205, Prince Frederick, Maryland 20678

of ay as is IME

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 3:40A M January 2006 Pauline F. Lipscomb /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Union Memorial Hospital Baltimore Baltimore City If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min Months Days 1 M 2 T 79 Director 214-24-9710 01/05/1927 Usual Residence of Decedent death with the Maryland or 28a-f show 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits Ves 2 No MD Baltimore City Baltimore Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "naturel", or items 23a or traumatic event, the Medical Examiner must be 614 Venable Avenue 21218 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If Item 27 te marked other than "naturel", or Ite 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Own Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Hinkle Virginia Johnson ၉ 19a. Informant's Name/Relationship (Type, Pnnt) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Debbie Beavers/Niece 19 Bay View Road Chesapeake City, MD 21915 or other 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Jan 18 4 □ Donation 5 □ Other (Specify) Beltsville, Maryland Chesapeake Crematory Inc. 2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives - Sne Ritter MO 144 8717 Green Pastures Drive Baltimore, Maryland 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (gras a consequence 163H **Physician** 2163 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit mon Division of Vital Records, P.O. Box 68760, mic Cordiornyopoth Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☑ No Month 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ icate has been sig r, page 2 should b 1 2 Yes 2 □ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 DNO 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Dinpatient 2 ER/Outpatient 3 DOA this After th funeral 28c. Injury at Work? 27. Mannes of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending death. M 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) January 17, 2006 University Parkway use of death (Item 23a) (Type, Print) Memorial 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [00888 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Duris 2006 9:50A M Jan 16 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Rising Sun
If Under 1 Year | If Under 24 Hrs. Cecil 269 Ebenezer Church Rd 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) Months Days Hours 1 □ M X 🛛 F Yrs. 212~22~9195 81 August 6,1924 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2¥ No Maryland Cecil Rising Sun 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 269 Ebenezer Church Rd. 21911~2716 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes X No Specify: White Specify 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Engineering Domestic Engineer ll yrs. N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Brooks Webster, Jr. Margaret Lavinia McCoy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Regina Lacy Wilt (Daughter) 1734 Forrest Avenue Baltimore, Md. 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Parkwood Cemetery 1~20~06 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. A aure of Funeral Service Licensee Lassann Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Chrenic Due to (or as a consequence of) Saventially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) 23d. Date of delivery Ectopic pregnancy Month Day Year Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed

Physician /Medical Examiner

Department of important: If any injury or once.

Physician

/Medical

Examiner

Funeral

Director

Items 23s or 28s-f show

other traumatic event, the Medical

Baltimore, Maryland 21215-0036

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Physician/Medical

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Certification: To

Medical

29a. Certifier

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unding physicien and use as the burial-transit atter for u certificete has been signi ector, page 2 should be within 24 hours efter death

To the Funaral Director: A

completely filled in by the f

The law requires that the death certificate be executed

Hospital or Attanding Physician:

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregrant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 [5 [
Part II. Other significant condition	as contributing to death but not resulting in t	he u

Hospital:

t II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	

28a. Date of Injury

25. Was case examiner? 1 \(\subseteq \text{Yes}	referred to medical
27. Manuer of	Death

		20. Flace of De	atii C	HELK OHE OHE				
tpatient	3□ DOA	Other: 4 Nursing H	Home	5 Residence	6 ☐Other (Specify)			
ime of	28c. Injury at		28d. Describe how injury occurred					

21.	Manuer of Death	
	1 Natural	5 Pending
	2 Accident	investigation
	3 Suicide	6 Could not
	4 ☐ Homicide	determined

1 🗌 Inpatient	2 🗆	ER/Outpatient	3□	DOA	Other: 4	Nursin	g Home	5 Residence	6 Othe
Date of Injury (Month, Day Ye	ar)	28b. Time of Injury		28c.	Injury at Work?			. Describe how inj	
			М		1 🗌 Yes	2 🔲 No			

	(Moriti, Day 16al)	injury	M		2	
8e.	Place of Injury - At he building, etc. (Specify	me, farm, street,	factory,	office		

)	
	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Unej	and manner star
29b. Signature and title of certifier	1
1 1 6/1	mal

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

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2 2 No

Wi	lli	al	m	1

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2 No

30. Name and address of person William

_	7	Milam	en	6301	N.	Charles	54	Baltimery
pora	A.	A :	(Mon 20a) (Typ	70, 1 milly		6 5	C. 1	O 17

State Registrar 31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien@ 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** JACques LAUTUre : 30 AM TAN 3006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORY HOSPICE STELLA MARIS IMONIUM 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours 12M 2DF Days Months 579-62-3123 HAITI AUG. 25 Director Usual Residence of Decedent 10d. fnside City Limits 10c. City, Town or Location 10b County 10a State r than "naturel", or iteme 23a or 28a-f ehow the Medical Examinar must be notified at 1 Yes 2 No BALTIMORE Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S. A 21218 LAKeside AUR 1708 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) ACCOUNTS Granger CORP 12+4 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Luire La Fontant LAUTUre JUSTIN ၉ 19b. Maifing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health an
Important: If item 27 is
any injury or other trau BAlto. MD 21206 6170 RADEKE AVE KAren 1) UN hAM 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 120/06 4 Donation 5-Other (Specify) ENTOWN brief T. GARdens of Faith Cem. PAUL STELLA FUNERAL HOME PA 7577 has Food RO. DALTO. MO 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) eukemia **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury) Due to (or as a consequence of) Certification: To Be Completed by Physician/Medical Examiner

or Attending Physician: The law requires that the death certificate be executed To the Hospital or Attending Physician: The law requires that the death certificate be execut within 24 hours attending by the attendant.

To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the Inneral director, page 2 should be detached for use as the burial-tran Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If Item 27 is marked other than "naturel", or Iteme 23a or 28a-f ehow

Baltimore, Maryland 21215-0036

that initiated events resulting in death) Last	cDue to (or as a consected.	quence of):						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of		23d. Date of delivery Month Day Year						
	ontributing to death but not re	sulting in the underlyi	ng cause given in Part I.		co use contribute to the cause of death? 2 No 3 Probably 4 Junknown			
				24a. Was an autopsy performed	24b. Were autopsy findings available prior to compfetion of cause of death? 1 □ Yes 2 □ No			
25. Was case referred to medical	26. Place of Death (Check only one)							
examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4 Nursing H	Home 5 ☐ Residenc	e 6 Other (Specify) Hospice			
27. Manner of Death 1. Dratural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	iniury occurred			
27. Manner of Death 1. Aratural 2	28e. Place of Injury - At h building, etc. (Speci	iome, farm, street, fa fy)	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier 12 Certifying Ph	ysician: To the best of my kn niner: On the basis of examin and manner stated.				e(s) and manner as stated. and place, and due to the cause(s)			
29h Signature and title of certifier	29c. License number				29d. Date signed (Month, Day, Year)			

D43725

2300 DULANEY VALLEY

29d. Date signed (Month, Day, Year)

JANUARY 16, 2006

State Registrar

DHMH 17 Rev 1/2001

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29b. Signature and title of certifier

Tarig

31. Date filed (Month, Day, Year)

MD

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Mahmoo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TIMONIUM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | | | | | = For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year AM CHARLOTTE MAE LIGHTFOOT 2006 8:07 15. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner # 102 4801 HIGH HAWK CT. COLUMBIA HOWARD If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 03 · 1 · 1929 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 K F 16 217-20-6945 Yrs Director MD Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 ehow traumatic event, the Medical Examinar must be notified at HOWARD 1 ☐ Yes 2 No MD COLUMBIA Direct 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 5 CT. #102 Itema 23a 4801 HIGH HAWK 21D45 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after ☐Yes 2**X** No f Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 5 Specify: BLACK 1 ☐ Yes 2 1 No Completed by 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. COOK FOOD SERVICE 8/14 GRADE NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental I HARRY GREENE BERTHA ALLEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #102 permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any njury or other trai once. (HUSBAND) 4801 HIGH HAWK (T. JAMES 4. LIGHTFOOT COLLMBIA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CROWNSVILLE 01.19.06 CROWNSVILLE , MD 21. Signature of Funeral Service Licensee VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATU PIKE, BALTO, MD 21229 2)angha 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner errosclevalic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events or as a consequence of) Examiner iding physician and use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed perleusion resulting in death) Last Due for as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day signed by the a 4 Pregnant at time of death 5 Dther (specify) 9 Unknown 9 Unknowe Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗆 Yes 3 Probably 4 Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2000 certificate 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 | Inpatient 2 | ER/Dutpatient 3 | DOA Other: 4 Nursing Home 1 ☐ Yes 2 No မ Sesidence 6 Other (Specify) this After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Direct completely filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D36246 Name and address of person who completed cause of death (Item 23a) (Type, Print) Roesler Rd Glen Barnie MD 21060 Rober MD Moune 31. Date filed (Month, Day, 32. Registrar's Signature State 500 Vil Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 6 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10:30 A M TANUARY Faith Logan 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HOSPITAL BALTIMORE AGNES **Baltimore City** If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2XF Days Hours Min. Yrs. Director 86 508-26-2846 September 14, 1919 Nebraska Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural" any injury or other traumatic acceptance. 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland **Baltimore** Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 U.S.A 717 Maiden Choice Lane Apt. #114 Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give A
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur W. Medlar Lucy Fiske 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3606 Joycin Ct. Ellicott City, Maryland 21042 Ms. Lucinda Meyer Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation * 5 ☐ Other (Specify) 01/16/2006 Baltimore, MD Bavview Crematory
2. Name and Address of Facility 21. Signature of Funeral Service Licens Slack Funeral Home, P.A.

23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Immediate Cause (Fine) Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA **Physician** WEEK disease or condition resulting in death) /Medical Examiner 1 YEAR HEART CONGESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Be Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐ Pregnant at time of death 5 Other (specify) should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate 1 Yes 2 XNo 2 No Division of Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Magner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation filled in by the within 24 hours after deat To the Funeral Director: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P17605 Tiodora, Nice lesse 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TEODORA M. NICULESCU, SAHC, 900 CATON AVENUE, BALTIMORE, MARYLAND 21229 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Estar () Sal al Registrar 8 2009

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year Physici**n** 6.07AM EADERMAN AURICE JANUARY 16 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ORTH WEST MOUPITAL RANDALLSTOWN BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) AUG/19,1911 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Months Days Min Hours Yrs. Director 552-10-2943 94 W٧ Usual Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD BALTIMORE BALTIMORE 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 11 SLADE AVENUE #607 21208 itame 23a USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 MYes 2 □ No WWII If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 X No WHITE Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced "naturel', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. TEXTILE SALES **TEXTILES** othert 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental is marked **JOSEPH** LEADERMAN BLOOMA PETUSKY 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 i 4322 WOODBERRY STREET - UNIVERSITY PARK, MD 20782 ARTHUR LEADERMAN / 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BETH TFILOH CEMETERY 01/17/2006 WOODLAWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee un w 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 2 days /Medical Due to (or as a consequence of): Examiner FAILURE RESPIRATORY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physicien and stransit the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MYPERTENSION 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown peeu DIABETES 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? s certificete has t lirector, page 2 s 2 No 1 ☐ Yes 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No ို 1 patient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours after To the Funerel Dire To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and litle of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D0063322 ddr ss of perso who completed cause of death (Item 23a) (Type, Print) 30. Na COURT ROAD, RANDALLSTOWN, MD. HMANDEEP 5401 OLD 31. Date filed (Month, Day, Year)* 32. Apgistrar's Signature State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#5, perFH 1851, 1/19/06 TT State of Maryland / Department of Health and Mental Hygierie | | | | | | 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10 laurin Day **Physician** Month Year alhryn 2006 6:41AM arwain 151 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BON SECOURS HOSPITAL BALTIMORE CITY N/A7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 F 217-24-2453 Days 76 Yrs. Director 12/28/1929 CAROLINA Ν. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be multipled at ODEs. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director MD N/A BALTIMORE CITY 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 10 N. ROCK GLEN ROAD 21229 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo BLACK Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) YEARS 12TH NURSE MEDICAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MALCOLM HAMM **MENORA** MIDGETT ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) RITA OLIVER / NIECE 2936 WINCHESTER ST., BALTIMORE, MD 21216 20a. Method of Disposition
1 △ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State KING MEMORIAL PK +01/26/06 RANDALLSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature meral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE., BALTIMORE, MD 23a. Part 1 Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final SIPSIS **Physician** Syndrome disease or condition resulting in death) /Medical Due to (or as a consequence ol) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Dua to (or as a consequence of): Hospital or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the a detached f 9 Unknown 9 🗌 Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records. enal failure 1 ☐ Yes 2 ☐ No 3 Probably 24a. Was an 24b. Were autopsy lindings available prior to completion of cause of death? page 2 autopsy performed; 1 Yes 2LXNo 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death | Check only one examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) January, 15, 2006 Name a and as of person who completed cause of death (Ite 23a) (Type, Print) Baltimora, 2000 West Baltimory Street 1(A)21)0 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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State of Marylai	State of Maryland / Department of Health and M					
1- State Registrar	Certificate of Death	Reg				
1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Dea		
Merle Edward` Marsellis		January	16, 2006	1:07P		
An English Name (If not institution, give street and number)	4h City Town or Location of Death		4c County of Death			

1:07P M

Physician /Medical

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Phy /N Exa

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death Division of Vital Records, P.O. Box 68760,

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	5. Social Security ! 242-46-		6. Sex 1 ⊠ M 2□ F	7. Age (In yrs. 61	last birthday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D 09/1			rthplace (State or Forei country)
or.	Usual Residence of 10a. State	10b. Count	ord		y, Town or Lo	ocation							10d. Inside City Lim
Director	10e. Street and Nu	ımber			рра	10f. Zip						en of What C	Country?
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by Funerai	11. Marital Status 1 ☐ Never Mar 3 ☐ Widowed		rned 1 Nes G	2 □ No		Was Deced If Yes, spec 1 Yes	cify Cuba	spanic Ori n, Mexicai Specify:	n, Puerto	ecify Yes or N Rican, etc.)		Black, Wh	
Completed	(Spe	cify only high	nt's Education est grade completed, College) (1-4or 5+)	(Give	dent's Usua kind of wo DO NOT us	rk done d	furing mos	t of worki	ing		d of Busines: htel C	s/Industry Corporation
Be	17. Father's Name			2	Engi	neer				(First, Middle		Sumame)	
မ			Marsellis							Thomas			
	19a. Informant's N Victori		ship <i>(Type, Print)</i> :llis/Wife		644	Har	bors		rive	Joppa			Zip Code)
	20a. Method of Dis t ☐ Burial 2 4 ☐ Donation	remation	3 □Removal from Specify)	State	Place of Disponentery, cre nesape	matory or c	ther plac			Jan 18 2006	1		r Town, State
	21. Signature of F	uneral Service	Licensee	w MO14	43 2					al Alten Drive			Maryland
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a												
ical Examiner	Sequentially list c if any, leading to cause. Enter Und Cause (Disease o that initiated event resulting in death)	erlying r injury ts	6	(or as a conseq									
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1							elivery Day Year					
			ions contributing to	death but not res	ulting in the u	ınderlying o	ause give	en in Part I		23e. Did	tobacco us	se contribute	to the cause of death
d by										1 Yes 2 No 3 Probably 4 Unknow			
Completed										24a. Wa auto perf 1 ☐ Yes		24b. Were a prior to death?	
Bec	25. Was case refe examiner?	erred to medic	at					26. Place	of Death	Check only			
2		(No	Hospital: 1	Inpatient 2	ER/Outpatie	nt 3 🗆 DC	Othe Othe	er: 4□N	ursing Ho	me 5□Res	sidence 6	Other (Sp.	ecity)HOSPI
	27. Manner of Dea 1 ⊠Natural 2 ☐ Accident	27. Manner of Death 1 Statural 5 Pending 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28c. Injury at 1 Statural 28c. Injury at 28c. Injury a						28d. Describe how injury occurred					
Certification;	3 Suicide 4 Homicide	6 🗌 Could deter	mined 289. Plac	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
Medical	29a. Certifier (Check only one)	1 Certify 2 Medica	ing Physician: To the Il Examiner: On the and ma	e best of my kno basis of examina nner stated.	owledge, deat ation and/or in	th occurred ovestigation	at the tim , in my op	ie, date ar pinion, dea	nd place, ath occurr	and due to the ed at the time	cause(s) , date and	and manner a place, and du	as stated. ue to the cause(s)
Σ	29b. Signature an	d title of certif	hong for	ly,	no)	1 /	C. License	- 10	5	4	-		nth, Day, Year)
	30. Name and add	tress of perso	n who completed cau	use of death (Iter	n 23a) (Type,	Print)	Carl	es Si	t. 1	balto	M.	121.	20%
ate	31. Date filed (Mo		32.	Registrar's Signa									

State of Maryland / Department of Health and Mental Hygienen Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 1015 A **Physician** Year Janumy 16 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FRANKLIN SQUARE HOSPITAL ROSSVILLE BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗡 F 061~70~5253 65 1,1941 Vietnam Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show ! 10b. County r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2√ No Maryland Baltimore Baltimore County Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4 Parham Circle #1B 21237 Vietnam 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Vietnamese Speck ietnamese ģ X8 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Homemakina-Elementary/Secondary (0-12) Cotlege (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dylan V. Mai (Son) 4 Parham Circle #1B Baltimore, Md. 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2XXCremation 3 Removal from State Metro Crematory Inc. 1~19~06 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral 7401 Belair Rd. Home Baltimore, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Physician 1-2 WKS /Medical Due to (or as a consequence of): Examiner 1-2 WKS NEUMUND Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760, 👉 Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ INDUNEWZA 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed ALUNE BERATIONS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No MASTUMA 1 Yes 2□ No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide within 24 hours a

To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1) 15 135 mmm January 11, soll 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BMAMME, MD 21237 9000 Frankin SU DINE PLANSWINE 1, SWIT MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			- State Registrar	laryland / Dep <i>Ce</i>	artment of H			ene 0	6 0	089	6
	Physic	ian	1. Decedent's Name (First, Middle, Last)				2. Date of Death	Day	Year	3. Time of Dea	ath
	/Medi	cal	Jose Mendoza		I a =		January	15 2	2006	2204	М
	Exami	ner	4a. Facility Name (If not institution, give street and number)	j	4b. City, Town, or		ath	4c. County of	of Death		
	Funeral		Johns Hopkins Bayview 5. Social Security Number 6. Sex 7. Aç	ge (In yrs. last birthday)	Baltimon	CE If Under 24 Hr	S. B. Date of Birth		9 Birtholas	no (State as Fo	
	Director		592-89-6097 1 [™] ¹ [™] ^{2□ F}	42 Yrs.	Months Days	Hours Mir	8. Date of Birth (Month, Day, 12-16-	Year) -1963		ce (State or For duras	reign
	pue ≱		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	conting						
	Maryli f sho	ō	MD n/a	Baltim					10d	I. Inside City Lir 1X\ Yes 2 □	
	r 28s	Director	10e. Street and Number		10f. Zip Code	<u>_</u>	10	g. Citizen of W	hat Country	92	
	deeth with the Marylend ms 23a or 28a-f show coust be notified at		345 S. Macon St.		2122	24		Hondu		r	
		Funeral	11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Specify Yes or No-	14. Race	- American	Indian,	
2000	rs afte	by Fi	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No	1X Yes 2 No		onduras	Specify:	, White, etc		
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2	P. P. P. P. P. P. P. P. P. P. P. P. P. P	ple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4ors	(Give	kind of work done di DO NOT use retired)	uring most of wo	orking	6b. Kind of Bus	iness/Indus	itry	
7	be filed within 72 hours after ital Hygiane. Id other than "natural", or ita svant, ita Madical Examine	Completed	12th		rehousem	nan		Rukert	Ter	minals	3
<u>a</u> nd	be fill d off	Be	17. Father's Name (First, Middle, Last) Jose A. Mendoza				me (First, Middle, M. Ca Roso I				
Ž	should be ind Mental inarked o	은	19a. Informant's Name/Relationship (Type, Print) WIF	E							
			Maria R. Mendoza		ng Address (Street ar S. Macon	nd NumberorR n St.Ra	ural Route Number, altimore	City or Town, S Marv	tate, Zip Co	nde) 21224	ı
กั	othe		20a. Method of Disposition	20b. Place of Dispo	sition (Name of		_	Oc. Location - C			
	Pege nent c ant: if		1 □XBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	Oaklawr	matory or other place	″ ¦1/2	0/2006 B		-		
	permit. Peges 1 and 2 Department of Health s Important: if Itam 27 is sny injury or other tra		21. Signature of Funeral Service Licensee	22	2. Name and Address	of Facility Jo	oseph N.	Zanni	no Ji	r FH	
_	E = 205	1	Maria A. Jennese) 2	63 S. CC	onklind	r St.Bali	imore	, MD	21224	Ĺ
	hysician /Medical			nshot wown a consequence of):	1 A .	2 A	c or respiratory arres	1,	Int	oproximate terval Between nset and Death	
,00	Dhysiclen and my the buriel-transit	dicai Examiner	cause. Enter Underlying Cause (Disease or injury) that initiated events	a consequence of):							
.0.	instant equies that the dean entiticate are the best been signed by the ettending phys bage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 4 Pregnant al 9 Unknown	23d. Date of delivery Month Day Year							
,	in signed build be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause							ause of death?	
	as been s 2 should	plet					24a, Was an	24h We	24b. Were autopsy findings available		
		e Completed	25. Was case referred to medical		7.		autopsy performe 1 2 Yes 2	d? deja	or to comple th? Yes 2	tion of cause o	of
Attending Bhusiolen	is certific director,	0 8	examiner? Hospital: 1 Inpatie	nt 2∏ER/Outpatient	1 04		th (Check only one)				
5	er thi	Ë	27. Manner of Death 28a. Date of Injur	y 28b. Time of	28c. Injury a Work?	4 Nursing H	ome 5 Residence		(Specify)		
ָרָבָּי בְּיִבָּיהָ בְּיִבְּיהָ בְּיִבְּיהָ בְּיִבְּיהָ בְּיִבְּיהָ בְּיִבְּיהָ בְּיִבְּיהְ בְּיִבְּיהְ בְּיִב	or: Af	atic	1 Natural 5 Pending 2 Accident investigation	0130	Work? 1 □ Ye	s 2 No	Subject	was st	205		
	fier de Iract n by t	Certification;		rv - At home, farm, stre			28f Lagation /Stm	donal Miraha	- 2 - 12	ute Number,	
1	ers e	ပ္	200 Continu	street			City or Town, S But hmose,				1
1	24 ho Fun etely	ledicai	29a. Certifier (Check only one) 1☐ Certifying Physician: To the basis of and manner sta	examination and/or inve	occurred at the time, estigation, in my opin	, date and place ion, death occu	, and due to the caus rred at the time, date	e(s) and manna and place, and	er as stated	cause(s)	
To the	within 24 hours elter death. To the Funersi Director: After the completely filled in by the funeral	Me	29b. Signature and title of certifier		29c. License n			Date signed (A			
,			- Sumot Garthall man		OCI		}	nuary,		,	
	1		30. Name and address of person who completed cause of de	ath (Item 23a) (Type, F		- -		Tucit y,	10, 4		
	2		Hamela E. Southall, MO		111 Peni	n Street	t Baltimo	re, Mar	yland	21201	
	Stat Registra		31. Date filed (Month, Day, Year) JAN 1 8 2006 32. Registra	r's Signature	13.5						

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

8 2006

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene O O C

			for State Registrar	State of Ma			ficate of l			Reg. No		00030
			1. Decedent's Name (First, Middle, Last	1)					2. Date of De Month		/ Year	3. Time of Death
	Physici /Medic		Edward Joseph M	cCarthy						y 16	2006	2:00 A. M
	Examir		4a. Facility Name (If not institution, give	street and number)	· · · · · · · · · · · · · · · · · · ·	4	b. City, Town, or	Location of Death		4c.	County of Death	
			Frederick Villa	Nursing H	ome		Caton	sville			Baltim	ore
	Funeral		Social Security Number 6. Se		(In yrs. last birt	A	Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th v, Year)	9. Birth	place (State or Foreign
	Director		223-24-3285	AM ZUF I	00	Yrs.			June 4,	1905		Hampshire
pue	*		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Local	tion					10d. Inside City Limits
Aaryl	9	ō	Maryland Baltimor	- 0		onsv:						1 ☐ Yes 2 ☑ No
the A	289	Director	10e. Street and Number		Cati	V. 2110	10f. Zip Code			10g Cit	izen of What Cou	
with	i i	ā					,	2			2017 01 171141 000	
Jeath	18 20 18 20	Funerai	124 Forest Avenue	12. Was Decedent E	ver in U.S.	13. Wa	2.122 as Decedent of H	5 ispanic Origin? (Sp n, Mexican, Puerto	ecity Yes or No	USA	14. Race - Amer	can Indian,
fler	흔	교	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 M2Yes 2 ☐ No	0				Rican, etc.)		Black, White	
urs a	. P	þ	3 ™ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 [Yes 2∭ No	Specify:			Specify:	White
aryianiq z 1 z 1 3-0030 should be filed within 72 hours after death with the Maryland	lical	Completed	15. Decedent's Edi (Specify only highest grad		16a.	Deceden	nt's Usual Occupa	ation	rina	16b. K	ind of Business/Ir	ndustry
Thin	. Wa	npie.	Elementary/Secondary (0-12)	College (1-4or 5+				furing most of work)				
M De	ygien t, th	ပ်		4	Но	rtic	ulturis				ral Gov	ernment
Vialid build be file	tal H d ott	Be	17. Father's Name (First, Middle, Last)	M = C = = +1==				18. Mother's Nam			Sumame)	
oud blue	Mer Parke	2	Thomas Fitzgerald						Ouilet			
Val	le m		19a. Informant's Name/Relationship (7)			-		and Number or Rui		-		
t and	Health		Patricia Deeley 20a. Method of Disposition	Daughter				venue; Ca	Date		cation - City or T	
5 8	10 = 10 = 10 = 10 = 10 = 10 = 10 = 10 =		1 Burial 2 ☐ Cremation 3 ☐				ion (Name of tory or other place	1				
Dallimor Sermit. Pages	rtmer		4 Donation 5 Other (Specify		Mt.Hope	e Pre	esbyteri	an 1/21	/2006	Hot	Springs	, Virginia
	Department of Health and Mental Hygiene. Importent: If item 27 Ie marked other than "naturel", or items 23s or 28e-1 ehow any injury or other traumatic event, the Madical Examinat must be notified at once.		21. Signature of Funeral Service Licens	70	127	22. N	Funeral	ss of Facility Ste Home of	Catonsv	ille	, Inc.	WILZKE
			23a. Part1. Enter the disease, or comp	dications that caused t	the death. Do r			ondson Av			ville, l	AD 21228 Approximate
			shock, or heart failure. List only of Immediate Cause (Final	one cause on each line	∍.				o. rouphatory a	11031,		Interval Between Onset and Death
	ysician Medical		disease or condition resulting in death)				's Disc	e ase				(pars
	aminer			Due to (or as a	consequence	ot):						1
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	consequence	ol):						
uted	dansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									
D,	en an rial-tr		resulting in death) Last	Due to (or as a	consequence	ol):						
VISION OF VITAL MECONDS, P.O. BOX 00/00, Attending Physicien: The law requires that the death certificate be executed	physicien and the burial-transit	edicai	(d								
	On of	Med	IF FEMALE:									
ath ce	ttend or use	lan/	23b. Was decedent pregnant in the past 12 months?	23c. II yes, outcome o 1 □ Live birth 2	Fetal death		ctopic pregnancy				23d. Date of deliv Month	ery Day Year
. e	the a	Physician//	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at t 9□Unknown	ime ol death	5□0	other (specify)				WOTH	Juy / Ju
F F	ad by detac	P.	Part II. Other significant conditions co	ontributing to death but	t not resulting in	the unde	arlying cause give	an in Part I	23a. Did t	obacco u	ise contribute to	the cause of death?
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	has ge 2	Completed							24a. Was autopento		prior to co	opsy lindings available omptetion of cause of
VILAI icien: Th	ficete or, pa	e Co	25. Was case referred to medical					00 DI 11 DI 1	1 ☐ Yes	2 No		2 □ No
sicie	recto	o Be	examiner?	Hospital: 1 ☐ Inpatien	nt 2□ER/Ou	toationt	2□ DOA Othe	26. Place of Deat			0 000	
2 g	ar this aral d	7: To	27. Manner of Death	28a. Date of Injury (Month, Day		ime ol	28c. Injun		28d. Describe		6 ☐Other (Speci y occurred	ry)
VISION	ith. :: Afte	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		Year) Ir	njury		(? Yes 2 □ No				
Atte	octo	ifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	286. Place of Injul	ry - At home, fa	rm, street	t, lactory, office		28f. Location (Street an	d Number or Rur	al Route Number.
5 8	s effe al Dir ad in	Certification:	4 - Homeldo	building, etc.	. (Зреску)				City of 70	wii, State	7	
ospit	within 24 hours effer death. To the Funeral Director: After this certificete has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use.	edical (29a. Certifier 1 Certifying Phy	sician: To the best of iner: On the basis of	f my knowledge	, death o	ccurred at the time	ne, date and place,	and due to the	cause(s)	and manner as	stated.
å.	iin 24 the F iplete	edi	one)	and manner stat	ed.							
٥	To con	Σ	29b. Signature and title of certifier Augus Bal	ATT UP			29c. License			_	e signed (Month,	
								58676		240	nary	4,2006
16	1		30. Name and address of person who o	completed cause of de	ath (Item 23a) (Type, Pri	int)	te 200 1	Victor	· 20.	10 101)	2113/
1	CH	ato.	Caren L. Babit 1 31. Date liled (Month, Day, Year) JAN 1 8	32. Redistra	r's Signature	N C	0 100	,	C 13 77 13	1-C	1	01776
3,	Sta Registi		JAN 1 8	2006	w Is	A	and I					
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene [] [Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month January 10:45PM™ Frances Α. Miller 14, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Nursing Center Baltimore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 26, 1923 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 82 Yrs. 215-12-8400 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6101 Loch Raven Blvd. Apt.305 21239-2697 U.S.A. r death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Unit Manager BG &E Pages 1 and 2 should be filed vitneric of Health and Mental Hygie rtant: if item 27 ie marked other 1 jury or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret С. Gollery Joseph L. Flaherty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret A. Schmitt/ Niece 1525 Roswick Avenue Rosedale, Maryland 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of important: if eny injury or once. Moreland Memorial Park 1/18/06 Baltimore, Maryland 22. Name and Address of Facility Leonard J. Ruck, Inc. 21. Signature of Funeral Service Licensee Heather Cain leather 5305 Harford Road Baltimore, Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Maysnaut
Due to (or ass consequence of): **Physician** monthe /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medicai as attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes No cate has page 2 s autopsy certificate 1 Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death |Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this nours after death.

neral Director: After this filled in by the funeral di 27. Manner of eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a
To the Funeral I
completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and the of centrer 29c. License number 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) Dodoo Blud Kaphael 5601 31. Date filed (Month, Day, Y 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of Ma		Departm Certific				Reg. No.	006	00900
*	Physic /Medi		Decedent's Name (First, Middle, Last, Reilly Francis Mull	er						ry 14,	2006	3. Time of Death 4:25 P M
	Examir	ner	4a. Facility Name (If not institution, give Good Samaritan Hospit	al			Baltim	pre			N/A	
	Funeral Director		5. Social Security Number 116-20-5618 6. Security Number 116-20-5618	7. Ag.	e (In yrs. last bin	Yrs. Mon	ths Days	If Under 24 Hours	Min. 8. Date of Month. May 28	Birth (2925)	9. Birth Mary	nplace (State or Foreign Pand
	Maryland a-f show	tor	10a. State 10b. County Maryland N/A		10c. City, Town							10d. Inside City Limits 1 X Yes 2 □ No
	h with the 23a or 28s	Funeral Director	10e. Street and Number 5302 Plymouth Road			10f	Zip Code 21214		2 - 2 - 14 - 2	10g. Citiz	zen of What Cou	untry?
9036	within 72 hours after death with the Maryland one. than "natural", or items 23a or 28a-f show ha Medical Examinar must be notified at	d by Funer	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1VVYes 2 D If Yes, Give Year or Dates:			ecedent of Hi specify Cuba s 2 No	spanic Origir n, Mexican, I Specify:	n? (Specify Yes or Puerto Rican, etc.)		4. Race - Amer Black, White Specify: Whi	etc.
1215-(be filed within 72 hours ital Hygiene. Id other than "natural", event, Ine Medical Exp	Completed by	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		+)	Decedent's (Give kind of life, DO NO Civil S	f work done a T use retired,	ation luring most o)	of working		nd of Business/li	,
Maryland 21215-0036		To Be Co	17. Father's Name (First, Middle, Last) Lawrence B. Muller			CIVII			s Nam <i>e (First, Mid</i> therine Rei	dle, Maiden		f the Army
	nd 2 sh lith and 27 is m r traum		19a. Informant's Name/Relationship (Ty Lawrence Muller/Son	pe, Print)	300	2 Clear	view Ave		or Rural Route Nu altimore Ma			ip Code)
Baltimore,	M O s.		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)		Most Ho	y crematory by Rede	or other place	1,	/19/06	Baltin	cation - City or T Tore Mary 1	
Bal	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licenson	Hilton	ر	5305	e and Addres rd J. Ri Harford	s of Facility UCK Inc Road	Båltimore M	aryland	21214	
R. S.	Physician / Medical Examiner (the prial-transit	Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List onty or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	10.	Atherus			WASCUL		>	Approximate Interval Between Onset and Death
O. Box 68760,	death certifi e attending i id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 □Ectopi 5 □ Other	c pregnancy (specify)			2	3d. Date of deliv Month	ery Day Year
S, P.	requires that the d een signed by the hould be detached	by	Part II. Other significant conditions con	tributing to death bu	ut not resulting in	the underlying	ng cause give	n in Part I.		d tobacco us		the cause of death?
	The law ate has b page 2 sl	Completed								rtopsy rformed?	24b. Were auto prior to co death? 1 \(\text{Yes}	opsy findings available impletion of cause of
Vita	Physiclen: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? The Yes 2 \(\text{No} \) No	ospital:			DOA Othe	~	Death Check on	21. Vi		
ō	ding h. After fune	tion: To	27. Manper of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatier 28a. Date of Injur (Month, Day	y 28b. T		28c. Injury Work	4 INUISI		e how injury		fy)
Division	al or Attensis after deatl	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	iry - At home, far . (Specify)	m, street, fac	tory, office		28f. Location City or	(Street and Town, State)	Number or Rura	al Route Number,
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifying Phys (Check only one) Medical Examir	ician: To the best of ler: On the basis of and manner sta	examination and ted.	Vor investigat	tion, in my opi	inion, death o	occurred at the tim	e, date and p	place, and due to	o the cause(s)
)	To the I within 2: To the I complet	W	29b. Signature and title of certifier	1. THE	_		29c. License	nedmun	Baltimare	29d. Date	signed (Month,	Day, Year)
6	119		30. Name and address of Person who co		eath (Item 23a) (Type, Print)	JH 12	eet i	Raltinia	- MA	11/1	217.01
	Sta Registr		31. Date filed (Month, Day, Year)		r's Signature	Sugar	£.,			1	1000	2///

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** MILTON, MEHLMAN JANUARY 16 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HOSPITAL RANDALLSTOWN NORTHWEST BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1₩ 2□F Months Days JUL.18,1917 219-32-0076 88 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other then "naturel", or items 23s or 28s-f show treumstic event, the Modical Examinar must be notified at 1 ☐ Yes 2 ☐ No BALTIMORE Director BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6604 SHELRICK PLACE 21209 USA 12. Was Decedent Ever in U.S. Agned Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 Never Married 2 Married WWII Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE 2 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SALESMAN MUSIC 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be BERNARD MEHLMAN ROSENGARDEN LENA ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ILENE URAM / DAUGHTER 6604 SHELRICK PLACE - BALTIMORE, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Depertment importent: If eny injury or 4 □ Donation 5 □ Other (Specify) BALTIMORE HEBREW CEM;01/17/2006 REISTERSTOWN, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Parf1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** RESPIRATORY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ettending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Miknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an HNEMIA 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Mpatient ٩ 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier JANUARY, 16, 2006. 10063322 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5401 OLD COURT ROAD RANDALLSTOWN, MD. HMANDEEP JINGH 31. Date filed (Month, Day, Year) JAN 1 32. Begistrar's Signature State Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month **Physician** 12 ERNEST NIPPER 2076 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ₹M 2 □ F 577-52-2731 66 February 19, Washington DC Director Usual Residence of Decedent 10d, fnside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-1 show 1 ☐ Yes 2 ☐ No Director Maryland Hyattsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20782 5669 Sargent Road United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 25 No ff Yes, Give Year or Dates: 14. Race - American Indian, 'natural', or iteme 11. Marital Status Black, White, etc. 1 Never Married 2 Marned Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Tractor Trailer Truck Driver Private Eighth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be fi Mental F permit. Pages 1 and 2 should be Department of Health and Mental Importent: If tem 27 is marked any injury or other traumatic evone. Erma King Albert Nipper 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5669 Sargent Road, Hyattsville, Maryland 20782 Barbara Jean Pitts Nipper/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition January 13 tx Buriaf 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 2006 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityRobert G. Mason Funeral Home Inc 21. Signatury of Funeral Service License 1661 Good Hope rd SE, Wash DC 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Belween Onset and Death Immediate Cause (Final **Physician** RESISTANT disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner DISEASE EWD STAGE RENAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or intury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner the attending physician and hed for use as the burial-transit SEPTIC Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□ Unknown detached 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 2 No 1 Yes the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 1 Nnpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? cal Certification: 1 Natural
2 Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 6 □ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of fniury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours after To the Funerel Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number

\$\Delta - 1.78.74\$ 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1-06-06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S-M-NAYAR MD 3717-38 AVE COTTAGE CLTY, MD 20722 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Joseph Committee 8 Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 5,2006 Alvester January 1605 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George County Hospital Cheverly Prince George If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 1921 9. Birthplace (State or Foreign Months Days Hours Min. (Month, Day, Year) 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2√√F 577-34-1770 84 February Washington DC Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits orient: if item 27 is marked other then "netural", or Iteme 23a or 28e-f show Injury or other treumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director District of Columbia Washington 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 4239 1st Street SE 20032 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ANo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 22 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ⊡√No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ent: If item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Tenth Domestic Worker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alfonza Lee Virginia <u>Coates</u> 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Samuel Neals/Husband 4239 1st Street SE, Washington DC 20032 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Bunal 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) January 14, Clinton, Maryland permit. Page Department of Importent: If any Injury or once. Resurrection 2006 22. Name and Address of FacilityRobert G. Mason Funeral Home Inc 21. Signature of Juneral Service Licensee 1661 Good Hope Rd SE, Washington DC 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Acute Coronary Syndrom Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year detached for in the past 12 months? 5 Other (specify) 4 Pregnant at time of death ☐Yes 2 No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ pe 1 Yes 2 No 3 Probably ESRD Dementia Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 1 ☐ Yes 2√2 No 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) To Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2X ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Medical Certification: Hospitel or Attending 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No hours after death unerel Director: A 2 Accident the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a 1 🗵 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1-6-06 MD. 12391 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Meer-Saiid Zonozi 1328 Southern Ave SE Washington DC #307 20032 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 8 2006 Registrar

DHMH 17 Rev 1/2001

			For State		•	partment of H 4万岁8月 6			leg. No.	5 00905
			Registrar Amend Ite 1. Decedent's Name (First, Middle, Las	<u>m #18 Per</u>	FH C821	1/18/00 3H	, out., .	2. Date of Dea	th	3. Time of Death
	Physicia /Medic		SHARON E. NICH	OL8ON_				Januar		06 2:55 P M
	Examin		4a. Facility Name (If not institution, give				Location of Death		4c. County of	f Death
			Johns Hopkins Hos 5. Social Security Number 6. S		je (In yrs. last birthda	Baltimo	re If Under 24 Hrs.	8. Date of Birth	n/a	9. Birtholace (State or Foreign
	Funeral Director			M 224 F	46 Yrs.	Months Days	Hours Min.	(Month, Day	Year) 1959	9. Birthplace (State or Foreign Country) MD
	yland now		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	•-f •	ctor	MO NA		BALTIMOR	E				1 X Yes 2 □ No
	or 28	Dire	10e. Street and Number		~~	10f. Zip Code			10g. Citizen of Wh	
	eath v	era	1616 N. WASHING	12. Was Decedent	EET	21213 3. Was Decedent of Hi		ecify Yes or No-	USA 14. Race	- American Indian,
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinat must be notified at	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 MEDivorced	Armed Forces? 1 Yes 2 L If Yes, Give Year or Dates:		3. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 125 No	Specify:	Rican, etc.)	0	White, etc. BLACK
Maryland 21215-0036	72 hou		15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. De	cedent's Usual Occupa	ition Juring most of work	ina	16b. Kind of Bus	ness/industry
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and	uld be f Aental I rked of tic eve	To Be	WILLIE COLE					MORRIS	Marris	
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ore,			20a. Method of Disposition 1 Magazian 2 ☐ Cremation 3 ☐	Removal from State	cemetery c	sposition (Name of rematory or other place		Date	20c. Location - C	ity or Town, State
Ĕ	mit. Pag partment portent: f r Injury o		4 ☐ Donation 5 ☐ Other (Specify)	KING PA		01.21			OMN, MO
Baltimore,	permit. Page Department o Important: ff any injury or once.		21. Signature of Funeral Service Licer		7	22. Name and Addres AUGHN C. G 151 BAUTO N	TTU PIKE !	BALTO, MA	21229	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	olications that cause one cause on each li	d the death. Do not ine.	enter the mode of dying	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
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	/Medical Examiner		resulting in death)	Due o (or as	a consequence of):					
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of):					
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	6						
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68760,	ficate be executed physician and is the burial-transit	edical	•	d						
	death certificate be execu e attending physician and id for use as the burial-tra		IF FEMALE:	23c. If yes, outcome	of pregnancy				22d Date	of delivery
Вох	eath certif attending for use as	Completed by Physician/M	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)			Mont	of delivery h Day Year
P.O.	thet the de ed by the detached	hysi	1 □ Yes 2 🌠 No 9 □ Unknown	9□ Unknown						
	w requires thet the been signed by the should be detache	oy P	Part II. Other significant conditions of			11	en in Part I.			oute to the cause of death?
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ecc	- 0 70	npie						24a. Was a autop	sv or	ere autopsy findings available or to completion of cause of
<u>~</u>	: The law cete hes , page 2 ;							perfor 1 ☐ Yes		ath? ∃Yes 2□ No
\ Zit	ysician: This certificete	Be	25. Was case referred to medical examiner?	Hospital:	(STED)(0	ient 3 DOA Othe	26. Place of Deat			(0.01)
6	Phys or this aral di	. To	1 🔀 Yes 2 🗆 No 27. Manner of Death	1 ☐ Inpatie		of 28c. Injury	4		ence 6 Other ow injury occurred	
ion	Attending Physician: r death. ector: After this certific by the funeral director,	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		ay Year) Injur	res 2 □No				
Division of Vital Records,	To the Hospital or Attending Phys within 24 hours effer death. To the Funerel Director: After this completely filled in by the funeral di	Certification:	3 Suicide 6 Could not b 4 Homicide determined	286. Place of In	jury - At home, farm, tc. (Specify)	street, factory, office		28f. Location (S City or Tow		or Rural Route Number,
	spital ours e ierei (29a. Certifier 1 ☐ Certifying Ph	ysician: To the best	of my knowledge, de	eath occurred at the tim	e, date and place	and due to the o	ause(s) and man	ner as stated.
	n 24 h	Medical			of examination and/or	investigation, in my or				
	To the comp	Σ	29b. Signature and title of certifier		200.	29c. License				(Month, Day, Year)
	. /		Maturell	von-T	Oller.	<i>^</i>	.M.E.	3	January 1	.6, 2006
	5		30 Name and address of person who	completed cause of		oe. Print) Penn Street	, Baltim	ore. Mar	yland 2	21201
	Sta	te	31. Date filed (Month, Day, Year)	32. Registi	rar's Signature		,	,	J	
5	Regist		JAN 1 8 2006	Jacobs.	B Las					

		•	For State Registrar	State of M	aryland / Depa <i>Cei</i>	artment of H rtificate of L			giene 6	009	06
			1. Decedent's Name (First, Middle, Las	st)				2. Date of Dea Month		3. Time	of Death
	Physici /Medic		Eugenia M. Nesl	oitt					y 3, 200		PM M
Cope and the	Examin		4a. Facility Name (If not institution, give			4b. City, Town, or		n	4c. County of		
			719 Maiden Cho:			Catonsv			Balti		
	Funeral Director		214-48-1093	9x 7. Aq □M 21X F	ge (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Sept 11	Year) 1915	Birthplace (State Country) Virginia	
	D S		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside	City Limits
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	ће № 28а-f	Director	MD Baltimo 10e. Street and Number	re	Catonsv	111e			10g. Citizen of Wh		
	with	ă	719 Maiden Choic	o Iana #6	24		228		USA		
	eath	era	11. Marital Status	12. Was Decedent	Ever in U.S. 13.	Was Decedent of Hi	spanic Origin? (S	pecify Yes or No-	14. Race -	American Indian,	
36	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23s or 28s-f show do other than "natural", or items 23s or 28s-f show event, the Medical Examinant in the notified at	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces' 1 ☐ Yes 2X If Yes, Give Year or Dates:	No	f Yes, specify Cuba 1 ☐ Yes 2 ☑ No	n, Mexican, Puerl Specify:	o Rican, etc.)		White, etc. white	
Maryland 21215-0036	72 hou natura dicul E	ted	15. Decedent's Ed	lucation	16a. Dece	dent's Usual Occupa	ation	rking	16b. Kind of Busin	ness/Industry	
212	within 7, ene. than "n	Completed	(Specify only highest gra	College (1-4or	life.	DO NOT use retired)	king			
7	d with giene. er that	ĕ	12	4		gistered			hea]	th	
9	e filed al Hygid other	Be (17. Father's Name (First, Middle, Last)						Maiden Sumame)		
<u>a</u>		٥	Oscar Hunter McC	lung				a Camero			
E.	and and is mu		19a. Informant's Name/Relationship (-		ng Address (Street a					21220
≥ .	5 # Z		John Nesbitt/spou	.se 		Maiden Ch	loice La	Date # 0 24			21228
	Pages 1 ar nent of Hea ant: If Item ary or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☑ Donation 5 ☐ Other (Specific		20b. Place of Dispo cemetery, cres	natory or other plac	e) 	Date	20c. Location - Ci	ty or Town, State	
Balt	permit. Pages Department of the important: If ite any injury or of once.		21. Signature of Funeral Arvice Licer	Wade /	ertor St	Name and Address tate Anato altimore,	omy Boar		Baltimo	re Street	t
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause	d the death. Do not ent	er the mode of dyin	g, such as cardia	or respiratory an	rest,	Approxim Interval B	letween
	Physician	0 3	Immediate Cause (Final disease or condition	C 2	ngestive	Heart	Fa.	, lead		Onset and	d Death
	/Medical		resulting in death)	u	s a consequence of):						
	Examiner										
	_	ē	Sequentially list conditions, if any, leading to immediate cause Enter Urbanying Cause (Disease or injury	Due to (or as	a consequence of):						
	cate be executed bhysician and the burial-transit	Examiner	that initiated events	c							
o	an ar	EX	resulting in death) Last	Due to (or as	a consequence of):						
8760,	ate be nysici he bu	cai		d						-	18.
39	ng pt ng pt as tl	Med	IF FEMALE:							30.000	
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be deteched for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month		Year
۳.	that the	P.	Part II. Other significant conditions of	ontributing to death	but not resulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contrib	ute to the cause of	f death?
ds	uires sign kd be	d by						1 🗆 Y	es 🏻 🖰 No 3	Probably 4	_Unknown
Records,	e law require has been si ge 2 should b	Completed						24a. Was a autop perfor	sy prid med? dea	re autopsy finding or to completion of ath?	
		မ Co	25. Was case referred to medical				26 Place of De-	1 ☐ Yes ath (Check only or		Yes 217 No	
Vital		o Be	examiner?	Hospital:	ient 2 ER/Outpatier	nt 3 DOA Othe	And in contrast of the contras		ence 6 □Other	(Specify)	
of	Physic this oral di	 	27. Manner of Death	28a. Date of Inj	ury 28b. Time o	f 28c, Injury	at at		ow injury occurred		
o	tending F death. tor: After the funera	謞	Natural 5 ☐ Pending investigation	(Month, Di	ay Year) Injury	Worl M 1 □	(? Yes 2 □ No				
Division	or A fter Direction by	Certification:	3 Suicide 6 Could not b 4 Homicide determined	259. Place of II	njury - At home, farm, str tc. <i>(Specify)</i>	reet, factory, office		28f. Location (S City or Tow	treet and Number n, State)	or Rural Route Nu	ımber,
	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by	edical C	29a. Certifier (Check only one)	ysicien: To the bes niner: On the basis and manner s	t of my knowledge, deat of examination and/or in tated.	h occurred at the tim vestigation, in my o	ne, date and place pinion, death occu	a, and due to the curred at the time, c	ause(s) and mann date and place, and	er as stated. d due to the cause)(s)
	ompl	₩ We	29b. Signature and title of certifier	7		29c. License		2	29d. Date signed (Month, Day, Year)	
	- >- 0		> //	(WI)		DY	ノイイノ		Janim	4 6 2	006
			30. Name and addr ss of erson who	7 711	March 1	Print)	Lane	Catensi	January ville Mi	yle.	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Regis	trar's Signature						
	Regist		JAN 18	2006	trar's Signature	perte					

Paul O'Brien Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. Amend Unpend item#1,23,27,28-1, penff.,532,2/2/00 11. State of Maryland / Department of Health and Mental Hygiene 06-00388 NJM For State Registrar 1-Certificate of Death Reg. No. 2. Date of Death Month Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 15 2006 January 1337 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 2-28 9. Birthplace (State or Foreign **Funeral** Days Hours 215-82-0187 3 Yrs. 1 NM 2□ F MARYLAND Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County other then "neturel", or Itams 23a or 28a-f ehow vent, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No THNE ARUNDE Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21061 5.A. Completed by Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc., filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Baltimore, Maryland 21215-0036 Specify: WhITE If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ESIDENTIAL AND PAINTER Elementary/Secondary (0-12) College (1-4or 5+) Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be and Mental le marked BRIEN SR. BEATILIA M. MATHEWS 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9a. Informant's Name/Relationship (Type, Print) ortment of Health a priant: If Item 27 is njury or other tra SR. FATHER GLENBURNEMD. 21061 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place 1 M Burial 2 ☐ Cremation 3 Removal from State Important: I eny injury o once. 4 □ Donation 5 □ Other (Specify) VETERANSCEMETERY 1-20-06 f Furnital Service Licenses 22. Name and Address of Facility 21. Signatu Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122 Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Narcotic and Alcohol Intoxication **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physicien and the burial-transit Due to (or as a consequence of) P.O. Box 68760. Physician/Medical as IF FEMALE use use 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the th 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۾ 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 2 🗆 No Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 \sum No 24a. Was an certificate Yes 2 No 26. Place of Death (Oneck only one) director. Be 25. Was case referred to medical examiner? Hospital: 1 Inpatient Other: Spital: 1 Inpatient R/Outpatient 3 DOA Cther:

28a. Date of Injury Par (Month, Day Year)

28b. Time of UNK 28c. Injury at Injury ٥ XXYes 2 □ No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this After the 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending 1 Natural 1/15/06 1 ☐ Yes 2 📆 No death. investigation 2 Accident within 24 hours efter death To the Funerel Director; completely filled in by the f 6 Could not be 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 3 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 728 Griffith Rd 4 Homicide Glen Burnie, MD Home 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

To the of

> State Registrar

31. Date filed (Month, Day, Year)

nd title of certifier

(Check only

29b. Signature



of peath (Item 23a) (Type, Print)

ORIGINAL

29c. License number

OCME

29d. Date signed (Month, Day, Year)

January, 16, 2006

111 Penn Street Baltimore, Maryland 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month Picek Katharine Edwards JANUARY 12:40P M 14, 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace County)

Tanhs | Days | Hours | Min. | Jan. 18, 1929 | California Saint Joseph Medical Center 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2**∑**F 76 421-42-9335 Director Usual Residence of Decedent filed within 72 hours after deeth with the Maryland permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinant he notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No MD Parkville Baltimore Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 8800 Walther Blvd. Apt. 1310 21234 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ģ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Own home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Lt. Gen'l Idwald Hubert Edwards Katharine Beirman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8800 Walther Blvd Apt 1310, Parkville, MD Charles R. Picek-husband 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place)
Hilltop Service Corp 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 1/17/06 Towson, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of FacilityRuck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HOURS CONSTRICTIVE PERICARDITIS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has have have a second to the Funeral Director. attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ ANASARCA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? 1X Yes 2□ No 2□ No 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 1 Yes 2 ER/Outpatient 3 DOA Certification: To 27. Magner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 🗌 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D 0060495 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER DRIVE TOWSON, MARYLAND 21204

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

8

2006

621

32. Registrar's Signature

			1 - For State Registrar		Marylar				lealth a		lental Hyg	jiene eg. No.	006	00909
	Physici	an	Decedent's Name (First, Middle, La	st)							2. Date of Dea Month	th Day	Year	3. Time of Death
9	/Medic		Sylvia G. Pa				,				January	16,	2006	5:15 P M
	Examir	er	4a. Facility Name (If not institution, give		ber)				Location of	of Death			County of Dea	
			Manor Care Ru				Rux		If I lades	Od Use			ltimor	
ь	Funeral			Sex 7 1 □ M 2 (3)(F		. last birthday) Yrs.	If Under Months		If Under Hours	Min.	8. Date of Birth (Month, Day	Year)	C	thplace (State or Foreign ountry)
-	Director		235-24-5304 Usual Residence of Decedent		86	113.					July 26,	191	19 Wes	st Virginia
	land		10a. State 10b. County		10c. C	ity, Town or Lo	cation							10d. Inside City Limits
	Many Feb	ō	MD Baltim	ore	To	wson								1 ☐ Yes 2 No
	r 28a	rec	10e. Street and Number				10f. Zip	Code		-		0g. Citiz	en of What C	ountry?
	3a o	D	205 E. Joppa Roa	d #1107			2	1286					USA	
	within 72 hours after death with the Maryland ene. than "naturel", or iteme 23s or 28s-f show the Madical Examiner must be mailited at	Funeral Director	11. Marital Status	12. Was Deced	lent Ever in U	J.S. 13.			spanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)	1	4. Race - Am	
9	or its	Ē	1 X Never Married 2 ☐ Married	1 Tyes 2	2 X No		ii Yes, speo 1 ☐ Yes			i, Puerto	Hican, etc.)		Black, Whi	
8	rel',	d by	3 Widowed 4 Divorced	Year or Dat	les:		T Tes	ZLAINO	Specify:				Specify:	White
2	72 h 'natu	Completed	15. Decedent's E (Specify only highest gro	ducation ade completed)		16a. Dece	kind of wo	rk done d	turina most	t of worki	ina	16b. Kin	d of Business	/Industry
2	of thin	μp	Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	DO NOT u	se retired,)					
Maryland 21215-0036	led w tygies her ti		12			Cler	ical		40.14.4				rnment	
ž	be fill Hall Hall Hall	Be	17. Father's Name (First, Middle, Last								(First, Middle,			
3	1 Mer narke	^L	George Papouts						Foti		Aspromo			
<u>a</u>	12 sh hand 7 is n treun		19a. Informant's Name/Relationship (Mary Padussis/si								l Route Number D7, Тош			^{Zip Code)} 21 286
e,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or iteme 23a or 28a-f show any injury or other treumatic event, the Madical Examination and be notified at once.		20a. Method of Disposition		20h	Place of Dispo								
altimore,	if its		1 Burial 2 Cremation 3 4 Dogation 5 Nother (Special	Removal from Si					e)				ation - City or	
Ħ	t. Partmer rtant		H		ent GI									, Maryland
Ba	Depariment Department of the property of the p		21. Signature of Funeral Service Lice		D C									Home, Inc.
3,	20244		23a. Part1. Enter the disease, or com	Stephen I						<u> </u>	wson, M		and 217	Approximate
%	Physician /Medical Examiner	Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events	a. Due to (o	GES as a consec	TIVE quence of):	an	d	15	CH	EMIC			Interval Between Onset and Death
x 68/60,	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	Physician/Medical Exa	resulting in death) Last IF FEMALE:	Due to (o	r as a consec							20	2d Data of do	lt.aa.
P.O. Box	that the death led by the atten detached for u	ysician	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	1 Live bir	th 2∐Feta ntattime of o	aldeath 3 ☐	Ectopic pr Other (sp					2.	3d. Date of de Month	Day Year
ري. م	s that	by Pr	Part II. Other significant conditions	ontributing to dea	th but not res	sulting in the u	nderlying ca	ause give	n in Part I.		23e. Did tol	acco us	e contribute to	the cause of death?
200	w requires that been signed I should be det	d b									1 🗆 Ye	s 2	No 3□P	robably 4 Unknown
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Ĕ	The lay	E									autops		prior to death?	completion of cause of
<u>r</u>	ifficat or, p	o o	25. Was case referred to medical						ac Diago	of Dooth			1 🗆 Yes	2 □ No
5	hysicien: The la his certificate hav I director, page 2	0	examiner? 1 □ Yes 2 🙀 No	Hospital: 1 🗆 Ing	nationt 2	ER/Outpatien	t 3 DO	Othe			ne 5 ☐ Reside		DO# (0	- 4.1
O	Physical controls	. To	27. Manner of Death	28a. Date of (Month,		28b. Time of		8c. Injury Work			28d. Describe ho			CITY)
0	tending leath. tor: After the funer	işi İ	1 Natural 5 Pending 2 Accident investigation		Day Year)	Injury	м		:? /es 2 □ N					
Division of Vital Records,	or At after of Direct in by	Certification:	3 Suicide 6 Could not be determined	28e. Place o	f Injury - At h g, etc. <i>(Speci</i>	ome, farm, stro	eet, factory	r, office		2	28f. Location (St City or Town	reet and n, State)	Number or Ri	ural Route Number.
	To the Hospitel within 24 hours a To the Funerel completely filled	edical	29a. Certifier (Check only one) Certifying Ph	nysician: To the b niner: On the bas and manne	is of examina	owledge, death ation and/or inv	occurred vestigation,	at the tim , in my op	e, date and inion, deat	d place, a	and due to the ca ed at the time, d	ause(s) a ate and p	and manner as place, and due	s stated. to the cause(s)
	To t	Σ	29b. Signature and title of certifier	2/1	1		29c	. License	number		2	9d. Date	signed (Mont	h, Day, Year)
}			1///	Wolland.	ims		2	4-0	012	84	9	/-	-17-	06 21204
	2		30. Name and address of person who	completed cause	of death (Iter	m 23a) (Type,	Print)	100	1.1	3				
	Ø	779	HH CHILD	D1. M	ク フ	600		540	R.	Dr	. lews.	iN	175	21204
***	Sta Registr		31. Date filed (Month, Day, Year) JAN 1 8 20	32, Rec	gistrar's Signa	ature	AP n							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** 6:25PM hanta z yelah January 15 2006 /Medical 4a. Facility Name (If not institution, give street and number) c. County of Death 4h City Town or Location of Death Examiner N/A University of Maryland Medical Center 5. Social Security Numberunk 6. Sex 7. Age (In yrs. last birthday) oftmare If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01-08-2006 Birthplace (State or Foreign Country)
 MD **Funeral** Months Hours Min. 1 M 2 TF Director Usuel Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 28e-f show treumatic event, the Medical Examiner must be notified at 1. Yes 2 No MD Director BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö items 23a 1608 W. LEXINGTON STREET 21223 USA

14. Race - American Indian,
Black, White, etc. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 ☑ Never Married 2 ☐ Married ☐Yes 2 No Baltimore, Maryland 21215-0036 ō Specify: BLACK 1 ☐ Yes 2 No Specify: ģ If Yes, Give 23. Year or Dates: 3 Widowed 4 Divorced 'naturel', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene important: If item 27 is marked other the any injury or other treumatic event, I'm 9008. N/A N/A N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SAMUEL PRICE ပ TYWANA POINTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TYWANNA POINTER/MOTHER 1608 W. LEXINGTON ST., BALTO., MD 21223 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ARBUTUS 01/21/2006 BALTIMORE, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee JAMES A. MORTON & SONS F.H., INC 1701 LAURENS ST., BALTO., MD 21217 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Filipsicial schemic Necrosis of Midgut /Medical Examiner astroschisis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner burial-transit death certificate be executed Due to (or as a consequence of): attending physician Box 68760 Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ rematurit 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ▼No 1 (Inpatient 2 2 ER/Outpatient 3□ DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Year) 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) determined 4 T Homicide To the Hospitel o within 24 hours aff To the Funerel Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai (Check only one) 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number AU4176435F16770 January 15, 2006 aumstide

State Registrar

DHMH 17 Rev 1/2001

22 S. Greene Street Room N5W68, Baltimore Mb21201

address of per or who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Mobolaji Hamuyide

JAN 1 8 2006

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiepen 1 5 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Margaret B. Parsons January 13, 2006 12:27 A^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery General Hospital 01ney Montgomery 8. Date of Birth (Month, Day, Year)
July 23, 1925 Pennsylvania If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 X F Director 212-24-2959 80 Usual Residence of Decedent with the Maryland 10h County 10c. City, Town or Location tem 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Madical Examinar must be notified at 10d. Inside City Limits Maryland Montgomery Rockville 1 ☐ Yes 2X No Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20853 4414 Aspen Hill Road United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ If Yes, Give Year or Dates: Specify: 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Insurance Company Subrogation Specialist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Harding Marie Lozaw 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John M. Bostwick / Son 251 East 11th Avenue, Escondido, California 92025 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State January rtant: If i 1 Burial 2 □ Cremation 3 □ Removal from State Arlington National Cemetery 26, 2006 Arlington, Virginia njury 4 ☐ Donation 5 ☐ Other (Specify) permit.
Dep. rtn
Imports
any nju 21. Signature of Funeral Service Licensee 22, Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc. Grealett tons M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 5 day morrha /Medical Due to (or as a consequence if) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence on physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Ician/Medical as the attending I for use as IF FEMALE: 951 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year 4 Pregnant at time of death 5 Other (specify) the detached Physi 9 Unknown 9 Unknown Ś Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed peeu Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? page certificate Door C 2 DNO 1 Yes 2 No π Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ 1√0 ဂ္ 1 Thoatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 DNatural 5 Pending investigation 1 Yes 2 No Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar (Check only one)

lobert

31. Date filed (Month, Day

29b. Signature and title of certifier

me and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Prince

18101

àr's Signature

29c. License number

D0061681

Philip Prive, olney MD

29d. Date signed (Month, Day, Year) January 16 2006

		1 - For State Registrar	State of N	Marylan				lealth a		1ental	Hygier Reg. i	C U U D	0	091	2
Physicia	an	Decedent's Name (First, Middle, Las	*	arrish						Mont	of Death	Day Ye	ar	3. Time of	
/Medic	al	Georg 4a. Facility Name (If not institution, give			1	4h Cit	. Tour	Location (of Dooth	Janu		2°, 2006		7:41	РМ
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Funeral		Social Security Number 6. S	x 7.	Age (In yrs.	last birthday)		er 1 Year	If Under Hours	24 Hrs.	8. Date	of Birth			ace (State or	Foreign
Director		579-10-3129 12 Usual Residence of Decedent	M 2□F	87	Yrs.	Month	Days	Hours	Min.	May	of Birth h. Day, Yea 2, 19	18 Wa	shi	ngton,	D.C.
I Z I 3-UU30 within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show than Madical Examinar must be notified at	<u>_</u>	10a. State 10b. County		10c. Cit	ly, Town or Lo								10	d. Inside Cit	
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with t	直	10e. Street and Number 2 Cedar Court				101. 2	ip Code 2085]	ı				Citizen of Wha			
death	by Funeral Director	11. Marital Status	12. Was Decede	nt Ever in U	.S. 13.	Was Dec		ispanic Ori in, Mexicar	igin? (Sp	ecify Yes		Ited St			
or ite	Fur	1 ☐ Never Married 2 🎇 Married	Armed Force	No			ecify Cuba 2 No			Rican, etc	C.)	Black, V	Vhite, e	tc.	
D-UCSO 72 hours af natural', or	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date:	s: WWII		TES	24 <u>34</u> NO	Specify:				Specify:	Whi	Lte	
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Marylan d 2 should be th and Mental 7 Is marked traumatic ev		19a. Informant's Name/Relationship (7										y or Town, Sta		Code)	
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141		30. Name and address of person who o	ompleted cause of	f death (Iten	n 23a) (Type,	Print)		11	0	_					
7		Ajit P. Kuruvilla	, M.D.	4		ille	Pike	, #20	8, R	ockvi	Llle,	Mary1a	nd 2	20852	
Sta Registr	-	31. Date filed (Month) Pay Year) 8 2	006	strar's Signa	ALUTS A	as of	7								

DHMH 17 Rev 1/2001

	1-	For Stete Registrer		, ,		artment of H <i>rtificate of L</i>				Reg. No.	UUb	009
	1.	Decedent's Name (First, Middle	e, Last)						2. Date of De	ath		3. Time of E
an cal		Jorge Luis Ro	que						Month 01	10	2006	07:3
ner	4a.	. Facility Name (If not institution	n, give street and n	number)		4b. City, Town, or	Location of	Death		4c. (County of Dea	ath
		Casey House				Rockvi	11e				Montg	gomery
		Social Security Number	6. Sex 1 25M 2 ☐ F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hours	4 Hrs. Min.	8. Date of Bis (Month, Da	rth ay, Year)	9. Bi	rthplace (State or Country)
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		sual Residence of Decedent Da. State 10b. County		10c. Ci	ity, Town or Lo	neation						10d. Inside City
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일	ı	Manuel Roque				Ì	Est	her	Foron	da		
		9a. Informant's Name/Relations Maritza Roque/				ng Address (Street a						
	1-	Da. Method of Disposition		20b. I	-	osition (Name of	T	-	ate		eation - City o	
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DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

JAN 1 8 2006

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Robert Thomas Reed 13, January 8:00 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10033 Colebrook Avenue Montgomery Potomac | Months | Days | Hours | Min. | Sept. 14, 1944 | Washington, D.C. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1⊠M 2□F 579-58-1227 61 Yrs Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits or 28a-f show The Medical Examiner must be notified at 1 Yes 2 No Director Maryland Montgomery Potomac 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 10033 Colebrook Avenue 20854 238 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status a filed within 72 hours after if Hygiene. other than "natural", or ite 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manager/Stock Broker Brokerage Firm or other traumatic event, permit. Peges 1 and 2 should be file Department of Health and Mental Hy important: If Item 27 is marked other any injury or other traument 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Walter Reed Helen Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10033 Colebrook Avenue, Potomac, Maryland 20854 Dorinda D. Reed/Wife Date 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Gate of Heaven January 1

Burial 2

Cremation 3

Removal from State Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2006 Cemetery Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase. Inc. 21. Signature of Funeral Service Licensee Kobert A. Pumphrey Funeral Home/ Chase, I 7557 Wisconsin Ave., Bethesda, MD 20814-3501 Inc. M00198 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myelodysplastic Syndrome /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ettending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) ed by the detached Ö 9 Unknown 9 Unknown signed by Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 ☐ Yes 2X No 1 ☐ Yes 2 ☐ No Division of Vital Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) ۵ 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) To the Hospitel or Attending Pt within 24 hours after death.
To the Funerel Director: After the completely filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: 5 Pending investigation s after dea. s after dea. eai Director: Aftr 1 XNaturai 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Addical Examilier. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier and manner stated. use and title of certified 29b. Signat 29c. License number 29d. Date signed (Month, Day, Year) 03 January 13, 2006 30. Name and address of person pleted cause of leath Jem 23a) (Type, Print) 10 401 North Broadway, Baltimore, Maryland 21231 Steven David Gore, M.D. 31. Date filed (Month, Pay, Year) 32. Asgistrar's Signature State 2006 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie [] [Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Beatrice A. Russell P M 14, January 2006 5:00 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 114 Hesketh Street Chevy Chase Montgomery If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 1 ☐ M 2 🗙 F 149-14-5010 80 16, 1925 New Jersey Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 X Yes 2 ☐ No Maryland | Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20815 114 Hesketh Street United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Press Officer Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thomas F. Crowley Beatrice Pearson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael W. R. Meyer / Partner 114 Hesketh Street, Chevy Chase, Maryland 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State January 17, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc Bethesda, Maryland 2006 21. Signature of Funeral Service Licensee Robert A. Rumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 M01305 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Intracerebral Hemorrhage 1 Month Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

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Funeral

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If itam 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Modical Examinar most be notified at

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permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy important: if Itam 27 is marked othing any liury or other traumatic event 2008.

the Maryland

with (

filed within 72 hours after death

Baltimore, Maryland 21215-0036

Box 68760, physician Division of Vital Records, P.O.

Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit ate has been signed by the attending physpage 2 should be detached for use as the funeral director, After n 24 hours after death.

The Funeral Director: After the further of the further the furthe

Examiner Physician/Medical Š Completed Be Certification; To

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. autopsy performed? Yes 2 X No 1 Yes 25. Was case referred to medical 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending Injury ↑ Tyes 2 No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

13

29b. Signature

within 24 ho To the Fund completely f To the l

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Peter G. Hamm, M.D. 5530 Wisconsin Avenue, #930, Chevy Chase, Maryland 20815

29c. License number

D32033

29d. Date signed (Month, Day, Year)

January 15, 2006

State Registrar 31. Date filed (Month, Day, Year) 8 2006



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Marylan	-	tment of He ificate of D		Mental Hy	giene Reg. No.	JU0 1	00916
	Physici		1. Decedent's Name (First, Middle, Last, June D	Ry	00			2. Date of De Month	Day		3. Time of Death
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give RIVERVIEW C 5. Social Security Number 6. Se 217-10-7847	ARE Cente	last birthday)	4b. City, Town, or £ 55 G If Under 1 Year Months Days		h 8. Date of Bi	4c.	County of Death 3 A L T / 9. Birthr	17707 Colace (State or Foreign
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36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel; or Items 23e or 28a-f show any injury or other treumatic event. The Medical Examinar must be notified at anone.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 🖫 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		as Decedent of His Yes, specify Cubar		Specify Yes or N to Rican, etc.)	i	14. Race - Americ Black, White, Specify: whi	etc.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year Dorothea Audrey Shaduk 4:45 15 2000 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltmore Washington Medical Center

15. Sex 7. Age (In yrs. last birthday) Glen 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday)
79 Yrs 8. Date of Birth (Month, Day, Year) 03/09/1926 Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 KF 215-22-2159 Director MD Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director Anne Arundel 1 Yes 22 No Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7975 Crain Highway, Apt. 323 21061 or items 23a United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced "netural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) filed within at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Balto. Co.Schools Administrative Assistant 12 permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: If Item 27 is marked oth ery lajury or other traumatic event SME. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Admiral Dewey Montley Amelia Gaither ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Frederick Shaduk/Husband 2504 Gramercy Circle Parkville, MD 21234 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Jan 18 20c. Location - City or Town, State 1 ☐ Burial 2 SCremation 3 ☐ Removal from State Chesapeake Crematory Inc. 2006 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Cremation and Funeral Alternatives 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Baltimore, Maryland 21286 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 3 mon the /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner use as the burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed end that initiated events resulting in death) Last Due to (or as a consequence of). attending physicien P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Completed 1 Yes 2 No 3 Probably 4 Unknown

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24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident Injury 5 Pending 1 Tes 2 No investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) tale Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth Year

1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** eona anulery 2006 /Medical c. County of Death 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street end number) **Examiner** Datimork romwel If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Yeer) Nov. 30,1918 5. Social Security Number Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Days 1□ M 2□ F 214-18-1660 87 Yrs Maryland Director Usuel Residence of Decedent Peges 1 and 2 should be filed within 72 hours efter deeth with the Merylenc 10d. Inside City Limits 10c. City, Town or Location 10a. Stete 10b. County 1 ☐ Yes 2 ☐ No Baltimore Directo Maryland Towson ?? is marked other than "naturel", or items 23a or 28a-f traumstic event, the Medical Examiner must be notified 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code Foxway Terrace 21286 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Meritel Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: ģ Specify 3 X Widowed 4 ☐ Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Mt. Vernon Mills 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Spees Vinson John Willard Roberta Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Health Hem 27 Dale S. Doeller / Daughter 10 Foxway Terrace Towson, Maryland 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 DXOther (Specify) Entombment Druid Ridge Mausoleum 1/19/06 Pikesville, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 any 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of Examine or Attending Physician: The law requires that the death certificate be executed Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. physicien Physician/Medical the Due to (or as a consequence of) for use es Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? sete hes been signed by the open page 2 should be deteched 1 ☐ Yes 2 TNo 3 Probably 4 Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? 2 0 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 No Certification: To 1 Yes 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 Tyes 2 No death. investigetion within 24 hours efter death.

To the Funeral Director: A completely filled in by the fi 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 - Homicide Hospital Medicai 1 Descritifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifler 110059855 un 16 Ringlin GAO, MD 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

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State of Maryland? Department of Health and Mental Hygiene () () 6 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** January 11, 2006 Shian McNeal Schnell 10:56 p.™ /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 145 Winter Harbor Drive Ocean City Worcester County 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 MM 2 □ F 56 213-54-1456 Director 08/18/1949 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Nes 2 No MD Worcester Ocean City Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 145 Winter Harbor Drive 21842 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 🗷 🗓 Specify: 3 ☐ Widowed 4 ☑ ivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Construction Elementary/Secondary (0-12) College (1-4or 5+) Painter 10 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Theodore C. Schnell Beatrice N. Cottle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. John C. Schnell/Brother 403 Denton Way Abingdon, MD 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2. **Cremation 3 ☐ Removal from State Jan 18 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory Inc. 2006 Beltsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 21286-23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Methadone intoxication and cocaine use Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 □ No 24a. Was an autopsy performed? 1XYes 2□ No 25. Was case referred to medical Be 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA tX Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify At Scene ၉ Certification: 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation Fnd 1/11/2006 | Fnd 10:56AM 1 ☐ Yes 2 No unk 6 X Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) 145 Winter Harbor Dr. 4 Homicide Found at residence Ocean City, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier icai (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME January 13, 2006 person who completed cause of death (Item 23a) (Type, Print) 1111 Fenn Street Baltimore, Maryland 21201 9BIULLAH 31. Date filed (Month, Day, Year)

State Registrar

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		.g	Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
1	Physici /Medic		Madeline M. Shourd	5				Jan	16 2006	12:10 PM
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		1 For State Registrar	State of M	larylan	-	artmen <i>tificat</i>			ind M	_	giene Reg. No	1 U U b	009	22
9		1. Decedent's Name (First, Middle, La	st)						-	2. Date of De	ath		3. Time of 0	Death
Physic /Med		Anna Louise S	Shafer							Month January	Da - 12		10:30	, м
Exami		4a. Facility Name (If not institution, give)		4b. City,	Town, or	Location of		January		. County of D		
	14 1 1/2	5727 Shookstown	Road			Free	deri	ck				Freder	ick	
Funera	12	5. Social Security Number 6. S	Sex 7. A	ge (In yrs. I	ast birthday)	If Under		If Under 2		8. Date of Bir	th	9.	Birthplace (State or Country)	Foreign
Director		214-34-1169	1□M 21∏F	80	Yrs.	Months	Days	Hours	Min.	(Month, Da 10/04			MD	
P .		Usual Residence of Decedent												
how	_	10a. State 10b. County		10c. City	r, Town or Lo	cation							10d. Inside City	•
Ba-f.	cto	Md Frederi	ck	Fre	ederic	c							1 🗆 Yes	2X No
ith th	Director	10e. Street and Number				10f. Zip	Code				10g. Ci	tizen of What	Country?	
filed within 72 hours after death with the Maryland Hygiene. Hygiene then "naturel", or iteme 23a or 28a-1 show ont, ite Medical Exercit entirest to recition		5727 Shookstown	Road			217	02				US	SA		
des man	Funeral	11. Marital Status	12. Was Decedent Armed Forces		S. 13. \	Vas Deced	lent of Hi	spanic Orig	in? (Spe	cify Yes or No Rican, etc.))-		merican Indian, /hite, etc.	
or it		1 Never Married 2 Married	1 ☐ Yes 2 🔯			1 ☐ Yes		Specify:	,				rinte, etc.	
72 hours naturel',	d by	3 Widowed 4 Divorced	Year or Dates:				- 142 . 10	Spoony.				Specify:	White	
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ygie ygie	ပိ		4		Regi	stere	d Nu					dical		
tal H	Be	17. Father's Name (First, Middle, Last)					18. Mother	r's Name	(First, Middle	, Maider	Sumame)		
should be and Mental a marked o	2	Robert Grimes						Ann	a De	rn				
and and is m		19a. Informant's Name/Relationship	Type, Print)		19b. Mailir	g Address	(Street a	nd Number	r or Rura	l Route Numb	er, City	or Town, State	e, Zip Code)	
and and Balth n 27		Paul D. Shafer	Husband					wn Ro	ad F	rederi	ck M	D 2170	2	
Tite T		20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 □	Bomoval from State		lace of Dispo em <i>etery</i> , cren	sition (Nan natory or o	ne of ther place	e)	D	ate	20c. L	ocation - City	or Town, State	
Pages nent of ant; if its		4 Donation 5 Other (Speci	y)		Olive	t Cem	eter	v .0	1/16	/2006	Fred	larick	MD	
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Menial Hygiene. Important; if item 27 is marked other than "nature any light or other traumatic event, IL & Madical once."		21. Signature of Fundral Service Lice	nsed /		22	. Name an	d Addres	s of Facility	Keer	ney & B	asfo	ord FH	111/	
80 = 80		John lax	Mari)	10	6 Eas	t Ch	urch	Stre	eet Fre	deri	ck MD	21701	
**		23a. Part 1. Enter the disease, or com shock or heart failure. List only	plications that cause	d the death	. Do not ent	er the mode	e of dying	g, such as o	cardiac o	r respiratory a	rrest,		Approximate)
Physician		Immediate Cause (Final	METHS	72170	· Asser	BOAR	CINO	MA	× C	THE- B	MA	Lett	Onset and Do	eath
/Medical		disease or condition resulting in death)	Due to (or as			0 7 17		/1	61	140	~~~	3 4	10 YEAR	23
Examiner														
	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	s a consequ	ience of):								-	
uted	声	cause. Enter Underlying Cause (Disease or injury that initiated events												
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ficat phy sthe	g		- U											
ires that the death certificies that the death certification is given attending the detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregna	ncy							23d. Date of	dolinos	
atte	ciai	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a			Ectopic pro						Month		ear
y the check	Ş	1 ☐ Yes 2 12 No 9 ☐ Unknown	9□ Unknown											
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ysician: The is certificate hadirector, page	S									1 Tes	rmed?	death	'es 2□ No	
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ding Ph h. After th funeral	ü	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28 a. Date of Inju (Month, Da	ay Year)	28b. Time of Injury	2	Bc. Injury Work	at ?	2	8d. Ďescribe	how inju	ry occurred		
endin eath. or: Aft	Sati	2 ☐ Accident investigation				М	1 🗆 Y	′es 2□N	10					
r Att	#	3 Suicide 6 Could not be determined	286. Place of in	jury - At ho tc. (Specify	me, farm, str	eet, factory	, office		2	8f. Location (Street ar	d Number or	Rural Route Numb	er,
To the Hospital or Attending Physician: The law requires that the death certify within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Certification:									·				
l hou unei unei	ledicai	29a. Certifier 15 Certifying Pl	nysician: To the best miner: On the basis of	of my know	wledge, death	occurred	at the tim	e, date and	place, a	nd due to the	cause(s	and manner	as stated.	
the F in 24 the F plete	edi	01707	and manner si	tated.	-VII allWOLIN	esugation,	птту ор	milion, death	ii occurre	at ine time,	uate ant	u place, and c	iue to the cause(s)	
To t To t	Σ	29b. Signature and title of certifier	Vs a				License					/-	onth, Day, Year)	
		Mosel ()	Course 1	Mp			03	176			1	112/	06	
10		30. Name and address of person who	completed cause of	death (Item	23a) (Type,	Print)						-		
10		BRIAN M. O'		40	507 4	J. 52	NEN	174 3	10	FREL	ER	ck	no 217	101
S	tate	31. Date filed (Month, Day, Year)	32. Regist	rar's Signat		49 -			1					
Regis	tror	IAN 1 Q 0	000		S Por	B.CAR								

Mrs. Louise Shafer

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend I tem 2 per dvr 8851 1-18-06 vt
State of Maryland / Department of Health and Mental Hygiene 116 11923

	•	1 - State Registrar			Cen	tificate of	Death		Re	g. No.	100	000	fines C
Dhysia	an	Decedent's Name (First, Middle, La.							ate of Death		2006 _{ar}	3. Time of	
Physic /Medi		MARTIN GARY SMYL						JAI	WARY		200\ 5 ar	8:24	Рм
Exami	ner	4a. Facility Name (If not institution, giv. FREDERICK MEMORI	AL HOSPITA	AL		4b. City, Town, o FREDERI		Death			unty of Death DERICK		
Funeral		5. Social Security Number 6. S	ex 7. Age	e (In yrs. last bii	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (A	ate of Birth Nonth, Day,	Year)	Coun	lace (State o	r Foreign
Director		229-54-2094 Usual Residence of Decedent		63	713.		<u> </u>	Ja	n. 14,	1942	2 Virg	inia	
yland		10a. State 10b. County		10c. City, Tow	m or Loc	ation					10	0d. Inside Cit	
e Mar	ctor	Maryland Frederic	k	Frederi	lck							1 🗌 Yes	2 🔁 No
death with the Maryland me 23a or 28a-f ehow must be notified at	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen	of What Coun	try?	
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fter de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married	Amed Forces?		If	Vas Decedent of H Yes, specify Cuba	an, Mexican, I	Puerto Rican	i, etc.)		Race - Americ Black, White, (
ING ZIZIS-UUSO be filed within 72 hours after death with the Marylan hal Hygiene. d other than "naturel", or Iteme 23a or 28a-f ehow awent, the Mudical Examinar must be notified at	ρ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1	☐ Yes 2 No	Specify:			Spe	oc <i>ify:</i> Whit	е	
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DIVISION Of VITA within 24 hours after death. To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	edical	29a. Certifier 1 ✓ Certifying Pl (Check unity one) 2 ☐ Medical Example (Check unity one)	nysician: To the best miner: On the basis o and manner st	i examination ai	e, death nd/or inv	occurred at the til	me, date and opinion, death	place, and d occurred at	lue to the ca the time, da	use(s) and te and plac	manner as st	ated. the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. Licens			29	d. Date sig	gned (Month, I	Day, Year)	
		SMum, M.C) .			0	0055	793			1/14/	96	
Ój		30. Name and address of person who	completed cause of d	leath (Item 23a)	(Туре, І	Print) Freder	ick Me	moria	Hose	ital			
	ate	31. Date filed (Month, Day, Year)	32 Registr	ar's Signature	1	N.	***************************************						
Regis	rar	JAN 1 8 20	106	and the state of	1								

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Margaret E. Schymansky 16, January 2006 7:00 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1408 N. Rolling Road Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 12 F Yrs. Director 84 217-16-4702 Oct.15,1921 Maryland Usual Residence of Decedent the Manyland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits item 27 is marked other then "natural", or iteme 23s or 28s-1 ehow other traumatic event, II e Modical Examinar must be nutified at 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Catonsville permit. Pages 1 and 2 should be filed within 72 hours after death with the N Depertment of Health and Mental Hygiene. importent: If item 27 is marked other then "netter only injury or other traumatic. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1408 N. Rolling Road 21228 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 【No Specify: Specify: White 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Meat Cutter Food Fair 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard Clark Mary Lulu Brown ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 330 Bollinger Road; Littlestown, PA 17340 Gordon E. Payne Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Crest Lawn Mem. Park 1/20/2006 Marriottsville, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of FacilinSterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 2122 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARCINONA **Physician** VECTAL YECURRENT 5 YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed ettending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) <u>о</u>. been signed by the should be deteched 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? nis certificate his director, page 2X No 1 Yes 2 No 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: ٥ Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital within 24 hours a To the Funerel I Hospitai 1 Certifying Physician: To the birst of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Oertifier ionature and title of certific 29c. License number 29b 29d. Date signed (Month, Day, Year) ANUARY 16,2006 30. Name and address of person who completed cause of death (Item 23a) (Type Print) H a F 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of	of Marylar		artment of I				600) 6	00925												
			Registrar Decedent's Name (First, Midd	le. Last)			tineate of	Douin		2. Date of Deat	ng. No.		3. Time of Death												
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	/Medic Examin		4a. Facility Name (If not institution		mber)		4b. City, Town, o	or Location	of Death	January	_	y of Death	7.30 h												
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_	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under		8. Date of Birth		9. Births	place (State or Foreign												
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Division of Vital Records,	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 200. Place	of Injury - Al h ing, etc. (Speci	iome, farm, str fy)	eet, factory, office		2	18f. Location (Sti City or Town		ber or Rura	l Route Number,												
_	spital	a C	29a. Certifier 1- Certifyin	ng Physician: To the	e best of my kno	owledge, death	occurred at the ti	me, date ar	nd place, a	nd due to the ca	use(s) and m	anner as st	ated.												
	the Ho in 24 i the Fu	edicai	(Check only 2 Medical one)	Examiner: On the b	asis of examina ner stated.	ation and/or inv	estigation, in my o	opinion, dea	ulh occurre	d at the time, da	ite and place,	and due to	the cause(s)												
	To To COT	Σ	29b. Signature and title of certific	5	Bo	MA	29c. Licens		7 /)	1	d. Date signe														
•	/		7	any		1 1		05		7	1//	2/0	4												
	5		30. Name and address of person	who completed caus	se of death (Iter	m 23a) (Type,	Print)	2 =	- 1	0 -	2														
	Sta	te	31. Date filed (Month Day, Year,	32. F	Registrar's Signa	ature	1-10	1105		141															
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1-	For	State of Maryland / Department of Health and M	lental Hygiene	nnas
	For State Registrar	Certificate of Death	Reg. No.	0000
1. [Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of D

Physician /Medical Examiner

Funeral Director

with the Maryland r than "natural", or ttama 23a or 28a-f ahow tte Medical Examinar must be notified at filed within 72 hours after death other permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: If item 27 Is marked other any injury or other traumatic avant, 9068.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

ed by the attending physicien and detached for use as the burial-transit signed ద్ది page 2 should peeu has certificate director this After within 24 hours efter death To the Funeral Director: completely filled in by the

Hospital or Attanding Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

eath Month Day Year Sina Sharareh 2006 JAN 0649 4a. Fecility Name (If not institution, give street and number)
SHADY GROVE ADVENTIST HOSPITAL 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY ROCKVILLE 6. Sex 1 ☑ M 2 ☐ F If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 27 525-35-9235 Yrs. October 19, 1978 New Mexico Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Montgomery Gaithersburg Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20125 Green Run Courts 20886 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Maritat Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White ۾ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Handy Man Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Shahram Sharareh Violta Assemi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shahnam Sharareh/Uncle 9904 Tambay Court, Montgomery Village, MD. 20886 January 14, 20b. Place of Disposition (Name of complete, crematory or other place)
Park Lawn Memorial
Park 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 2006 4 ☐ Donation 5 ☐ Other (Specify) Rockville, Maryland 22. Name and Address of Facility Robert A. Pum Bethesda-Chovy Chase, Inc. Bethesda, Maryland 20814-3501 21. Signature of Fungal Cervicy Licensee Pumphrey Funeral Home/ The M01353 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Narcotic (methadone) intoxication resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of 1 es 2 No 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1X Yes 2 No 1 Inpatient 2 X ER/Outpatient 3 DOA

27. Manner of Death 1 Natural 2 Accident

3 Suicide

29a. Certifier

4 - Homicide

(Check only one)

5 Pending investigation 6 🕅 Could not be determined

28b. Time of Fnd 28a. Date of Injury (Month, Day Year) 6:00 A 1/10/2006 Fnd 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

found at home

28c. Injury at Work? 1 ☐ Yes 2 📉 No 28d. Describe how injury occurred unk

28f. Location (Street and Number or Aural Route Number, City or Town, State) 20125 Green Rum Court Gaithersburg, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

XMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

29c. License number O.C.M.E 29d. Date signed (Month, Day, Year) JAN. 11, 2006

30. Name and address of person who completed cause of death Item 23a) (Type, Print) <u>-m</u> TEODORE

111 PENN STREET, BALTIMORE, MARYLAND 21201

State Registrar

Certification;

Medical

31. Date filed (Month, Day, Year) JAN 1 8 2006

Please Type or Print in Black Indelible lak. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JAN. 12°, CATHERINE TAYLOR 2006 4:50 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 3910 MILFORD AVENUE BALTIMORE CITY N/A | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | O 3 / 1 6 / 1933 5. Social Security Number 213-30-3280 7. Age (In yrs. last birthday) 72 yrs 9. Birthplace (State or Foreign **Funeral** 1□M 2 F Yrs. Director MARYLAND Usual Residence of Decedent the Maryland 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow troumatic event, the Medical Examiner must be notified at MD N/A Completed by Funeral Director BALTIMORE CITY 1X Yes 2 □ No 10e. Street and Number 3910 MILFORD AVENUE 10f. Zip Code 10g. Citizen of What Country? 21207 USA Iteme 23a Pages 1 and 2 should be filed within 72 hours after deeth inent of Health and Mentat Hygiene. Int: If Item 27 Is marked other than "naturel", or Iteme 23 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Never Married 2 Married 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOSPITAL TECHNICIAN 12TH MEDICAL 17. Father's Name (First, Mid Brawner 18. Mother's Name (First, Middle, Maiden Sumame) Be RAYMOND BRANNER HATTIE TODD ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DARLEEN ROBINSON/DAUGHTER 7878 CORNER STONE WAY, BALTIMORE, MD 21244 other 20b. Place of Disposition (Name of cemetery, crematory or other place KING MEM. PARK 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5 permit. Page Department of Importent: If any injury or ance. 1/18/06 RANDALLSTOWN. MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD 21. Signature of uneral Service Licensee not enter the mode of dying, such as cardiac or respiratory arrest, . Enter the disease, or complications that caused the death. ix, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease of condition advancel **Physician** Coup Greations resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760, physician Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? eun'ou 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation 1 Natural Injury death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel L To the Hospital TS Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00063681 7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AJIT KURUP, 115 ROESLER RD, GLEN BURNIE, MD 21060 M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2006 Registrar

ORIGINAL

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	Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death	
	/Medic Examin	al	MARY WILL AMENA TO 4a. Facility Name (If not institution, give street and number)			Location of Death	01 /	6 2006 4c. County of Dea		
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248	Funeral Director		5. Social Security Number 6. Sex 7. Age ((In yrs. last birthday	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, You June 26,	1935 Mar	thplace (State or Foreign buntry) y Land	
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	3e or 28	i Dire	10e. Street and Number 42 Windemere Parkway		10f. Zip Code 21131		10g	. Citizen of What Co USA	ountry?	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Iteme 23e or 28a-f show any figury or other traumatic avent, I'm Macifiel Examinating any once.	by Funeral Director	11. Marital Status 1X Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Every Armed Forces? 1 Xes 2 No If Yes, Give Year or Dates: Was Decedent Every Armed Forces?		. Was Decedent of H II Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:		
8	2 hour	ted b	15. Decedent's Education	16a. Dec	edent's Usual Occup	ation	16	b. Kind of Business		
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	and 2 st lith and 27 lan		19a. Informant's Name/Relationship (Type, Print) Lola M. Keys (Sister)		lling Address (Street: Windemere			-		
Baltimore,	es 1 ar of Hea of Hea of Item r othe		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Disp		D		c. Location - City or		
Ē	t. Pag rtment rtant: I		4 ☐ Donation 5 ☐ Other (Specify)		Cemetery	1/19/		rkville,	Maryland	
Bal	Depar Impo		21. Signature of Funeral Service Licensee	-	22. Name and Address 3620 Wil	kens Ave.				
	4		23a. Part : Enter the disease, or complications that caused the shock, or heart lailure. List only one cause on each line	ne death. Do not ei	-			•	Approximate Interval Between Onset and Death	
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10	d		30. Name and address of person who completed cause of dea Suresh Shanlelyh 3900	ath (Item 23a) (Type	Ravi ~	Blul	Balhon	ine M	21218	
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	ns 23	Funeral	6845 Buckthorn G	12. Was Decedent Ev	er in U.S.	13. V	Vas Decedent of H	lispanic (Origin? (Spec	ify Yes or No		A. Race - Ameri	can Indian,	
40	fter d	Fun	↑ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2♥ No		If	Yes, specify Cuba	an, Mexic	can, Puerto R	ican, etc.)		Black, White	etc.	
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Division of Vital Records, P.O.	Physician: The la ir this certificate has sral director, page 2	0	examiner?	Hospital:	2 ER/	Outpatien	t 3 DOA Ott	205	,			6 ☐Other (Speci	fu)	
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	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funaral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier Certifying P	hysician: To the best of	my knowled	dge, death	occurred at the ti	me, date	and place, ar	nd due to the	cause(s) and manner as	stated.	
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	To t To ti	Σ	29b. Signature and title of certifier	1011	11		29c. Licens	se numbe	er		29d. Da	ite signed (Month)	Day, Year)	
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	12		30. Name and address of person who	ompleted cause of dea	ath (Item 23a	a) (Type,	Print)	-4	1	1		8	1	. ~~
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Funeral Director	~		_M 2∏F	90	Yrs.		Days	Hours Min		ay, Year)	1015 To	irthplace (State or Foreign Country) nnessee	
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		30. Name and address of person who con Saima Khawaja, M. I					Sui	te 100.	Rockwi 1	1e	Marula:	nd 20852	
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State of Maryland / Department of Health and Mental Hygiene 🎧 🎧 🦰 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Donald Williams January 14, 12:15 AMM 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Joseph Richey Hospice N/A Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1**25**M 2□ F Months Days Hours Min 84 214-16-8129 Yrs. Director 06/06/1921 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 27 is marked other then "natural", or Items 23a or 28a-f ehow treumatic event, the Medical Examinar must be notified at Yes 2 No Director MD Baltimore City Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 36 N. Gorman Avenue 21223 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ₹No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Construction Elementary/Secondary (0-12) College (1-4or 5+) Carpenter permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked other any loury or other treumatic event 20x8. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert D. Williams Beulah Williamson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris E. Williams/Wife 36 N. Gorman Avenue Baltimore, MD 21223 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Jan 21 1 ☐ Burial 2 🗷 remation 3 ☐ Removal from State Beltsville, Maryland Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives Suchetter MO1443 8717 Green Pastures Drive Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Fustone 6 mos /Medical Due to (or as a consequence of): Examiner stroinksting Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Inknown Due to (or as a consequence of): burial-transit inknown and Box 68760, ed by the attending physician detached for use as the buria ician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) o Physi 9 Unknown 9 Unknown نه Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Librillation 24b. Were autopsy findings available prior to completion of cause of death? Cilva 24a. Was an has autopsy performed? 1 ☐ Yes 2 🔏 No 2 □ No 1 Tyes of Vital nerel Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Magner of Death
1X Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After Division 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed, (Month, Day, Year) D0035712 Katharine Harrison MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 828N. Eutaw St. Bairo MD. 21201 Joseph Riche Hospice Harrisin MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State A STATE OF Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 115 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Frieda Μ. P M Wise 2006 3:57 January 14, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery General Hospital 01ney Montgomery Ulney
If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🕅 F 93 July 8, Ohio 230-26-2488 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County itam 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic event, the Medical Examples than notified at 1 ☐ Yes 2X No Director Maryland | Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 3508 Chiswick Court United States death Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. sm 27 is marksd other thsn "natural", or its 1 □ Yes 2**X** No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Piano Teacher Music 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Not Available Jones Maude Cramer 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itam 27 i 219 E. Gilein Avenue, Norfolk, VA Gerald Wise, Son 20b. Place of Disposition (Name of cometery, crematory or other place)
Quantico National
Cemetery Date 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1
Department of Hi
Important: If iten
sny injury or ott January 20, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 □ Other (Specify) Triangle, Virginia 2006 Robert A. Pumphrey Funeral Home, Rockville, Inc. 21. Signature of Funeral Service Licenses William a - Yunghey M01173 300 W. Montgomery Avenue, Rockville, Maryland 20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ses 2 No 3 Probably 4 Unknown page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 200 No 1 Yes To the Hospital or Attending Physician: filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifier D0063196 15 σ_i 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Philip Drive Olney, MD 20832 DAMOP 18101 Matthew C. 31. Date filed (Month, Day, Year) 32. Segistrar's Signature State Registrar

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To the Hoepitel or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death. To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1⊠ Certify	ing Ph	ysician: To t	he best	of my know	ledge, d	eath occurred at the ti	me, date an	nd place, an	nd due to the	cause(s)	and manner a	is stated.
Ho 24 h Fui stely	edicai	(Check only 2 Medical one)	al Exar	niner: On the	basis o	of examination	on and/o	r investigation, in my	opinion, dea	th occurred	d at the time,	date and	place, and du	e to the cause(s)
thi chi	Me	29b. Signature and title of certif	lier					29c. Licens	se number			29d. Date	e signed (Mor	nth, Day, Year)
1× 1× 00	-	L IC A	-	14.5	. 2	A O . T	1.0			62				162006
0		16		•								- 111,		
CL		30. Name and address of person	on who	completed ca	use of c	death (Item :	23a) (Ty	pe, Print) \ \ - S	· NA	0. FI	. 0			
0		5400 old	C &	77 +1:	#	= 108	2	andquist	n w	CM	21	(3.	7	
To Sta	to	31. Date liled (Month, Day, Yea			-	rar's Signatu								
Regist		171 N1 -1	0	1000	K		20 -	A AP.						

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 1 - For State Registrar Certificate of Death 3. Time of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 16,2006 Physician Janua /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Olumbia der 1 Year | If Under 24 Hrs. 4 Kehab. enter owara Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 ☐ M 2 👿 F Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itama 23a or 28a-f show any injury or other traumatic event, its Machinal Era plicat mast is natified at once. 1 XYes 2 ☐ No Completed by Funeral Director more Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Marital Status 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: lf Yes, Give ' Year or Dates: Specify: 3 NWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type, Print) (SOn) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) St Mic 301 denton, Ma. 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mem. Par 21. Signature of Funeral Service License 22. Name and Address of Facility Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between shock, or heart fair. Immediate Cause (Final Onset and Death dementia Alzheimeris years **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of) Box 68760, Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Vascular 3 Probably 4 Unknown 2 No 1 ☐ Yes n9 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 1 ☐ Yes 2 XNo 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🗆 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No M 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide 25a Geriffer X-Certifying Physiniam: To the best of my knowledge, death occurred at the time, date and plane, and due to the newsels) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 565 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD21044 Columbia, Hickory Ridge Rd, 10780 Ham 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

	For	ype or Frint in Black 124/1 State of Maryland / Departr	nent of Health and M	ental Hygier	PANA	00935
	1 - State Registrar		cate of Death	Reg. 1	No.	
Physician	1. Decedent's Name (First, Middle, Last	amor Aleton			2, 2006	3. Time of Death 12:54 P M
/Medical Examiner	4a. Facility Name (If not institution, give	street and number) 4b.	City, Town, or Location of Death		4c. County of Deatl	
Examine	3255 E Normandy V	Woods Drive E	llicott City		Ioward	
uneral irector	120-14-23/81		Under 1 Year If Under 24 Hrs. Onths Days Hours Min.	8. Date of Birth Month, Day, Ye.	9. Birth	nplace (State or Foreign untry)
Mo al	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location	n / / /			10d. tnside City Limits
Importent: If item 27 is marked other than "natural, or iteme 24s or 28e-1 enow any injury or other traumatic avent, the Madical Examiner must be notified at once. To Be Completed by Funeral Director	Maryland Howa	ard Ellicot	T CITY Of. Zip Code	10g.	Citizen of What Co	1 X Yes 2 ☐ No untry?
23a c	3255 Norm	nandy Woods Dr.	21043		USI	4
Funeral	11. Marital Status 1 Nover Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No	Decedent of Hispanic Origin? (Spe i, specify Cuban, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
by F	3 Widowed 4 Divorced	If Yes, Give 1 1	res 2 to No Specify:		Specify:B	ack
Completed	15. Decedent's Edu		Usual Occupation of work done during most of working	16b	. Kind of Business/	ndustry
du	Elementary/Secondary (0-12)	College (1-4or 5+)	OT use retired)	-t	Dontie	tru
ပိ	17. Father's Name (First, Middle, Last)	U Derii	18. Mother's Name	(First, Middle, Maid	len Sumame)	5119
To Be	Stanley J.	Alston Sr.	Berno	adette	Gay	
-	19a. Informant's Name/Relationship (7)	(Mother) 19b. Mailing Ac	dress (Street and Number or Rura	l Route Number, Cit	y or Town, State, Z	(ip Code)
	Mrs. Bernadette	e Brown 6405	Brook Au	e. Bal	to. Ma	.21206
	20a. Method of Disposition 1 Burial 2 Cremation 3 F	Removal from State 20b. Place of Disposition cometery, cremator	y or other place)	20c.	Location - City or	Town, State
	4 Donation 5 Other (Specify)	- Cheepinou		3/2006 E	Salto.	Ma.
	21. Signature of Funeral Service/Licens		ph L. Russ Fur	ieral Ho	me P.A. Mdi 210	27/
\vdash	23a. Part. Enter the disease, or comp	lications that caused the death. Do not enter the cause on each line.	mode of dying, such as cardiac o	r respiratory arrest,	Mdi 210	Approximate Interval Between
1	Immediate Cause (Final disease or condition	Narcotic Intoxication				Onset and Death
1 r	resulting in death)	Due to (or as a consequence of):				
١.	Sequentially list conditions,	b. ————————————————————————————————————				
ulne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				
Examin	that initiated events resulting in death) Last	c				
		d				
Med	IF FEMALE:					
Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		opic pregnancy er (specify)		23d. Date of deli Month -	very Day Year
by Ph	Part II. Other significant conditions co	ntributing to death but not resulting in the under	ying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
				1 ☐ Yes	2 □ No 3 □ Pro	obably 4 Unknown
plet				24a. Was an autopsy	prior to o	topsy findings available completion of cause of
Completed				performed 1 X Yes 2 □		2□ No
Be	25. Was case referred to medical examiner?	Hospital:	26. Place of Death Other: 4 A Nursing Hor			
2	1 Yes 2 No 27. Manner of Death	28a. Date of Injury Find 28b. Time of Fin	- Total and and and	me 5 Residence 28d. Describe how in		ofy) scene nk
la la	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury	Work? 1 □ Yes 2 X No			
Certification:	3 ☐ Suicide 6 XX could not be 4 ☐ Homicide determined		actory, office	28f. Location (Street	and Number or Ru	mandy Woods Dr
Cert		Found at residence	E	Ilicott Cit	y, MD	mainy woods Di
edical	(Check only 2 Medical Exam	rsician: To the best of my knowledge, death occ iner: On the basis of examination and/or investi				
Med	one) 29b. Signature and title of certifier	and manner stated.	29c. License number	29d.	Date signed (Mont)	n, Day, Year)
) Wi hi	m.D				
	30. Name and address of person who c	ompleted cause of death (Item 23a) (Type, Print	OCME	J	anuary 13	3, 2006
-	The second of th			.	. 1 1	01.001
-	LING LI	$m \cdot \supset$ 1:	<u>ll Penn Street B</u>	<u>altimore</u> .	Maryland	21201
State Registrar	31. Date filed (Month, Day, Year) JAN 1 9 20	32 trar's Signature		altimore .	Maryland	21201

			For State Registrer	State of Maryla		artment of I			giene Reg. No.	06 0	0936
	Dharaini		Decedent's Name (First, Middle, Last)					2. Date of De. Month	Day	Year	3. Time of Death
N. dies	Physici /Medic		Jessie Albiker					JANUARI	, , ,	2006	0646 AM
	Examin	er	4a. Facility Name (If not institution, give st	4.4	. (-1	0	or Location of De	eath	4c.	County of Death	
Ng.		5	5. Social Security Number 6. Sex	-5 17 100	. last birthday)	If Under 1 Year		Irs. 8. Date of Bir	th	N/A	place (State or Foreign
	Funeral Director			M 2X) F 87	Yrs.	Months Days		feb. 6	y, Year)		place (State or Foreign Intry)
			Usual Residence of Decedent	07				12 02 0		KCI	redeky
	how		10a. State 10b. County	10c. C	ity, Town or Lo	cation					10d, Inside City Limits
	Ba-f	cto	Maryland Baltimor	e I	oundalk						1 □ Yes 2√2 No
	ith th	Director	10e. Street and Number			10f. Zip Code	0			zen of What Cou	·
	e 23s	srai	833 Loalan Avenue	2. Was Decedent Ever in	15 13 1	2122		(Specify Yes or No		ted Stat	
36	be filed within 72 hours after death with the Maryland that hygiene. ad other than "naturel", or iteme 23a or 28a-f show event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2XXNo If Yes, Give Year or Dates:	'	f Yes, specify Cul 1 ☐ Yes 2 ☐XNo	oan, Mexican, Pu	uerto Rican, etc.)		Black, White Specify: Whi	, etc.
21215-0036	2 hour	ed	15. Decedent's Educ	ation	16a. Dece	dent's Usual Occu	pation		16b. Ki	nd of Business/li	ndustry
215	hin 7.	Completed	(Specify only highest grade Elementary/Secondary (0·12)	College (1-4or 5+)	life.	kind of work done DO NOT use retire	adring most of ed)	working			
21	filed within Hygiene. other then '	Com	10 years		Tin	Inspecto	T			anufactu	ring
pu	2 should be filed and Mental Hygi is marked other aumatic event, it	Be (17. Father's Name (First, Middle, Last)					Name (First, Middle,		Sumame)	
Maryland	should to and Ment marked umatic	ဥ	Joseph McGlone					ie Holbro		T 0 7	
Nar	2 sh and te m		19a. Informant's Name/Relationship (Typ					Rural Route Numb			
	s 1 and 2 should f Health and Men item 27 is marke other traumatic	133	Glenna Mayeski (Da 20a Method of Disposition	aughter)	_	Charles sition (Name of	mont Ro	ad Baltiı Date		cation - City or 1	
٥	m 0 - L		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	cemetery, crer	natory or other pl	1	12012000			
Baltimore,	그 문문을 .	1	4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	10/2000		ITY CEME 2. Name and Addi		/20/2006	EIK.	ridge, N	aryrand
Ba	Depa impo eny i		10000		D	uda-Ruck	Funera	1 Home of	Dun	dalk, Ir	nc.
w.			23a. Part1. Enter the disease, or complic	ations that caused the de-	ath. Do not ent	922 - Wise er the mode of dy	Avenue ing, such as car	Dundalk diac or respiratory a	rrest,	ryland /	Approximate Interval Between
	Physician		shock, or heart failure. List only on Immediate Cause (Final	Septic S	hask						Onset and Death
噻	/Medical	6 .	disease or condition resulting in death)	Due to (or as a conse							1 oan
2.7	Examiner			Urosepsis							3 days
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	nd rransi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Urin	tract	in faction					707
00	cate be executed oblysicion and the burial-transit	Ä	resulting in death) Last	Due to (or as a conse	iquence or):					1	
8760,	physic the b	dical	d								
Box 6	The law requires thet the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Sc. If yes, outcome of preg	tal death 3	Ectopic pregnan	су			23d. Date of deli	very Day Year
-	the a	ysic	1 ☐ Yes 2 SNo 9 ☐ Unknown	4☐Pregnant at time of 9☐ Unknown	death 5L	Other (specify)					
P.0	thet ti ed by detac	H.	Part II. Other significant conditions con	tributing to death but not re	sulting in the u	nderlying cause g	iven in Part I.	23e. Did 1	tobacco u	ise contribute to	the cause of death?
g	uires sign ld be	d by						1 🗆	Yes 2	□No 3□Pro	bably 4 Unknown
8	w requir been si should	Completed						24a. Was		24b. Were au	topsy findings available ompletion of cause of
Re	The tay sete hes page 2	E						— auto perfo	psy omed? 20 No	death?	ompletion of cause of 2 □ No
ta		0	25. Was case referred to medical				26. Place of	Death (Check only		, , , , , ,	
N N	ysici is cer direc	To B	examiner?	ospital: 1 npatient 2	☐ ER/Outpatie	nt 3 DOA	ther: 4 🗌 Nursir	ng Home 5 Resi	dence	6 □Other (Spec	ufy)
0	ng Pth ter th neral	ü	27. Manner of Death 1 Naturat 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Inj	ury at ork?	28d. Describe	how injur	y occurred	
Sio	Attendir death. ctor: Al y the fu	catio	2 Accident investigation				Yes 2 No				
Division of Vital Records,	or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, st cify)	reet, factory, offici	9	City or To			ral Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	edical Ce	(Check only 2 Medical Exemir	icien: To the best of my ker: On the basis of exami							
	thin 2 the the implel	Med	29b. Signature and title of confiler	and manner stated.		29c. Lice	nse number		29d. Da	te signed (Monti	n, Day, Year)
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,	~		30. Name and address of person who co	•	1					_/	1/ 0003
1	0 7		PATRICIK TRO	1 4940	EAST	ERN A	VEW UF	BALTIN	moi	e, mh	21224
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sig		AP 0				11.	
	Regist	rar	JAN 1 9 2006	Alexander Si	STORY.						

ician	Registrar	ma /First Middle I	act) T		Certificate of	Death	2 Date of Dea	Reg. No.	3	I. Time of Death
	1. Decodert 3 No.	- Laton	^{ast)} Latonya An via	ine Alston	Alston		JANUARY	Day	Year	0:22A. M
dical niner	4a. Facility Name		ive street and number)			or Location of Death		4c. County		U. ZZH.
miei		EMORIAL H			BALTI	MORE		N	IA	
al	5. Social Security	Number 6.	Sex 7. Age	e (In yrs. last birth	Months Days		8. Date of Birt	th v. Year)	9. Birthplace Country)	e (State or Foreign
,	212-96-	1133	1□M 21 F	31 Y	rs.		(Month Da	74		Md.
	Usual Residence	of Decedent 10b. County		10c. City, Town	or Location				10d.	Inside City Limits
ŏ	Md.		NA		Baltimore	.				M∏Yes 2∏No
Director	10e. Street and h	Number			10f. Zip Code			10g. Citizen of V	Vhat Country	?
	2600	Aisquith	Street		2	1218		13	ISA	
Funeral	11. Marital Status		12. Was Decedent E Armed Forces?	Ever in U.S.	13. Was Decedent of If Yes, specify Cub		pecify Yes or No o Rican, etc.)		e - American I k, White, etc.	
	NZ.	arried 2 Married	1 ☐ Yes 2 X N If Yes, Give	No	1 ☐ Yes 25 No			Specify		
d by		1 4 Divorced	Year or Dates:	160	December 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	anting		16b. Kind of Bu		
Completed	(Sp	15. Decedent's pecify only highest of	Education grade completed)		Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of wor	rking	160. Kind of 64	/siness/indusi	try
E	Elementary/Se	econdary (0-12)	College (1-4or 5	i+)	Superviso	r Custodi	an	Allianc	e Corn	١.
	12th g: 17. Father's Nam	ne (First, Middle, La.	3 yrs		Dupozvizo	1		Maiden Sumam		4
o Be	Ronald	đ		Alstor	ı	Belind	la	W	hyte	
_	19a. Informant's	Name/Relationship	(Type, Print)	19b.	Mailing Address (Stree	t and Number or Ru	ıral Route Numbe	er, City or Town,	State, Zip Co	de)
	Latars	ha K. Lew	is Si	ster	52 Six Not	ches Ct.,	Baltim	ore, Md.	212	28
	20a. Method of D		☐Removal from State	20b. Place of cemetery	Disposition (Name of r, crematory or other pla	асе)	Date	20c. Location -	City or Town,	, State
		n 5 Other (Spec		Greer	mount Cem.	1-1	.4-06	Balti	more,	Md.
	21. Signature of	Funeral Service Lic	ensee		22. Name and Addr	ess of Facility	Baltin	more, Md	. 212	202
	P 20	I dadi	omplications that caused	new	March F.			E. Nort		pproximate
ı	resulting in deat	lition (h)	Due to (or as	a consequence o	ortic Medial i: with Advent Artery		oma around	1 root of	Or	nset and Death
Examiner	resulting in deat	conditions, o immediate nderlying or injury ants	b. Aorta and Due to (or as	a consequence o	0: with Advent Artery ():		oma around	l root of	Or	nset and Death
_	Sequentially list if any, leading to cause. Enter UP Cause (Disease that initiated eve resulting in deat	conditions, o immediate nderlying or injury ants	b. Aorta and Due to (or as	a consequence of Pulmonary a consequence of	0: with Advent Artery ():		oma around	l root of	Or	nset and Death
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ORIGINAL

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

> ettending physicien and for use as the burial-transit within 24 hours efter death.
>
> To the Funeral Director: After this certificate has been signed by t completely filled in by the funeral director, page 2 should be detach

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

	5. Social Security N		6. Sex		7. Age (In	yrs. las		If Under		If Unde Hours		8. Date of Birt (Month, Da	v. Yearl	i C	thplace (State	e or Foreign
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recto	10e. Street and Nu		7110	1100				10f. Zip					10g. Citiz	zen of What Co	ountry?	
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ner	11. Marital Status		12.		edent Ever	in U.S.	13. \				rigin? (Spe an, Puerto F	cify Yes or No Rican, etc.)	- 1	14. Race - Ame Black, Whi		,
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Completed by Funeral Dir		15. Decede	nt's Educati	on			16a Deced	dent's Usu	al Occup	ation				nd of Business		
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	23a Part1. Enter shock, or hea	the disease, d art failure. Lis	or complicat st only one o	ions that o	caused the each line.	death.	Do not ent	er the mo	de of dyin	ig, such a	s cardiac o	r respiratory a	rrest-	DA"AJ	Approxin Interval i Onset ar	nate Between ad Death
	Immediate Cause disease or condition	(Final on	a	G	FLID	BL	ASTE	MUK.	4 1	Mu	アナン	arne	(D	TUMOR	4)	io Death
	resulting in death)			Due to	(or as a co	nseque	nce of):							•		
_	Sequentially list co	onditions,	b	Due to	(or as a co	nseque	nce of):									
u u	Cause (Disease of	eriying r injury	≺	500.0	(0. 40 - 00.											
×a	that initiated event resulting in death)	s Last	C	Due to	(or as a co	nseque	nce of):								<u> </u>	
Physician/Medical Examiner			d													
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Comple												24a. Was autor	osv	prior to	utopsy lindin completion o	igs available of cause of
5												1 ☐ Yes	2 No	death?	s 2□No	
Be	25. Was case rele examiner?	rred to medic							1 04		ce of Death	(Check only o	one)			
0	1 ☐ Yes 2 🗓	No			· · · · · · · · · · · · · · · · · · ·		R/Outpatier			4 🗆 !		ne 5 Resi			ecify)	
Ö	27. Manner of Dea 1 Natural	5 Pend	ding	28a. Date (Mor	of Injury oth, Day Ye	ar) 2	8b. Time o Injury	1	28c. Injur Wor	rk?		28d. Describe	now injur	y occurred		
cat	2 Accident 3 Suicide	inves 6 ☐ Could	stigation	- DI	- 41-1	A	- (М		Yes 2[704 Location /	Ctroat on	d Number or F	Dural Claude A	(
Ę	4 Homicide		mined	28e. Placi build	e of Injury - ling, etc. (S	pecify)	e, ram, str	reet, lacto	гу, опісе		· ·	28f. Location (. City or To			iurai Houle N	rumber,
Medical Certification:	29a. Certifier	1 Certify	vina Physici	ian: To th	e best of m	y knowl	edge, deat	h occurred	d at the til	ne, date a	and place a	and due to the	cause(s)	and manner a	as stated.	
dic	(Check only one)			: On the t		minatio						ed at the time,				se(s)
Me	29b. Signature and	d title of fertif	tier .		,			29	c. Licens	e numbe		7 /3	29d. Dat	e signed (Mon	ith, Day, Yea	r)
	> Kind	I	1_		M				DO	05	87	19	OI.	/13/	06	
	30. Name and add	iress of perso	on who comp	oleted cau	ise of death	(Item 2	23a) (Type,	Print)	11.0	154	100	0,5		~ ~	Cala	enbis 1
	KAR	LK	AZA	MO	N	W		103	40	-17	THE .	1 #Th	Xer	THK	NT "	2104
	31 Date liled (Mo	nth Day You		20.1	Danistanda	Signatu	**								1 1	- /7

Year

13, 2006 4c. County of Death

23

ARUNDEL

DHMH 17 Rev 1/2001

State Registrar

32. Registrar's Signature

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

JAN 1

9 2006

Soules

			For State Registrar	State of Maryland		rtment of H tificate of L			ene 2006 g. No.	00941
	Dhyoisi		Decedent's Name (First, Middle, Last)	7				2. Date of Death Month	Day Year	3. Time of Death
W.	Physicia /Medic		MARGARET	BLOOM				01	12 06	1 pm M
	Examin	er	4a. Facility Name (If not institution, give str	: 1/		4b. City, Town, or			4c. County of Dea	ith
	, , , , ,		North Arunder Healt	7. Age (In yrs. la	ne histosou	Glen Bu		8. Date of Birth	Anne Ar	
P.	Funeral		5. Social Security Number 6. Sex 1 1 1	7. Age (III yrs. 1a	Yrs.	Months Days	Hours Min.	(Month, Dey, 06/19/19		thplece (State or Foreign ountry)
W.	Director		Usual Residence of Decedent	19		<u></u> i		100/19/1	920 Do	altimore, MD.
	dand ow		10a. State 10b. County	10c. City,	Town or Loc	ation				10d. Inside City Limits
	Man	ţŏ	MD Baltimore	2	Balt	imore				1 ☐ Yes 2 ☑ No
	1 the	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
	h with		6212 Robin Hill Roa	Бе		21207		ī	Jnited Sta	tes
	deal deal	Funeral		2. Was Decedent Ever in U.S Armed Forces?	. 13. V	as Decedent of Hi	spanic Origin? (Sp n. Mexican, Puerto	pecify Yes or No-	14. Race - Am Black, Whi	erican Indian,
ဖွ	or Ite		1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 ☑ No If Yes, Give		☐ Yes 212 No	Specify:			ucasian
21215-0036	ural',	d by	3 ☑ Widowed 4 Divorced	Year or Dates:						
ν.	nati	Completed	15. Decedent's Educa (Specify only highest grade	ition completed)	(Give I	ent's Usual Occupa kind of work done o O NOT use retired	luring most of wor.	king	6b. Kind of Business	vindustry
7	Mithir sne.	d L	Elementary/Secondary (0-12)	College (1-4or 5+)		_	,		None	
7	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or Items 23s or 28s-f show ther then "natural", or Items 23s or 28s-f show ant, I'm Medical Evanicat must be notified at		12 17. Father's Name (First, Middle, Last)		ПОП	emaker	18. Mother's Nam	ne (First, Middle, M	None laiden Sumame)	
aŭ	d be	9 Be	John Jacob Rodemeye	r			T.i 11 i	an Louise	e Nothnage	1
Maryland	should and Men amarke umatic	P	19a. Informant's Name/Relationship (Type		19b. Mailin	g Address (Street a			City or Town, State,	
S	od 2 s		Linda S. Price		3501	Ath Str	ot Balt	imoro Mi	21225	
ē,	s 1 and 2 f Health Item 27 other tra		20a. Method of Disposition	CA	ce of Dispos	sition (Name of atory or other place	e)	Date 2	0c. Location - City o	Town, State
Ë	Pages nent of int: If Its iry or o		1 □ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from State		Cemetery		17/06 I	Baltimore,	MD.
Baltimore,	그 든 원 등		21. Signature of Funeral Service Licens	. 0	22	Name and Address	s of Facility Hu	bbard Fur	neral Home	. Inc.
m	Departiment of the post of the			med	4	107 Wilke	ens Ave.,	Baltimon	re, MD. 21	229
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death.	Do not ente	r the mode of dyin	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between
y.	Physician		Immediate Cause (Final disease or condition	()=	7000	Core	ivama			Onset and Death
	/Medical		resulting in death)	Due to (or as a conseque	ence of):					
10	Examiner		Sequentially list conditions. b.							
	D ::	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	Due to [or as a conseque	ence of):					
	cate be executed obysician and the burial-transit	хаш	that initiated events c. resulting in death) Last	Due to (or as a conseque	ence of):					
8760,	be exician burial	E		230 (0) 20 2 0000000	3.100 3.7,1					
87	physis the	dical	d.							
9 X	leath certific attending p	/Me	IF FEMALE: 23	c. If yes, outcome of pregnan	icy				23d. Date of de	elivery
Вох	atten for u	clan	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			Month	Day Year
P.O.	the d y the	Physician/Me	1 ☐ Yes 2 ₩No 9 ☐ Unknown	9□ Unknown						
	The law requires that the death certificate has been signed by the attending property 2 should be detached for use as	by Pi	Part II. Other significant conditions cont	ributing to death but not resul	ting in the ur	iderlying cause give	en in Part I.	23e. Did tob	acco use contribute	to the cause of death?
rds	quire n sign	d be	Coronery A	item Disa	on			1 ☐ Ye	s 2 No 3 F	Probably 4 QUnknown
Records,	s been si should l	olet		1				24a. Was ar	24b. Were a	autopsy findings available completion of cause of
Re	The law te has	Completed						autopsy perform	red? death?	s 2 No
ital	an: rtifica	O	25. Was case referred to medical				26. Place of Dea	ith (Check only one		
}	Physician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☒ No	spital: 1 Inpatient 2 E	R/Outpatien	3 DOA Oth	er: 4 🗷 Nursing H	ome 5 Reside	nce 6 Other (Sp	ecify)
0	ng Pl		27. Manner of Death 1 ⊠Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun World	/ at k?	28d. Describe ho	w injury occurred	
Sio	endin eath. or: A	catio	2 Accident investigation				Yes 2 □No			
Division of Vital	or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	ne, farm, stre	et, factory, office		City or Town	eet and Number or F , State)	Hufai Houte Number,
	urs a eral C		20a Contiliar 157 Continue Street	sign. To the heat of multi-	uladan dasah	occurred at the tr-	na data and alace	and due to the	usa/s) and manner	as stated
ñ	Hosi 24 ho Fune Fune	edical		ician: To the best of my knower: On the basis of examinati and manner stated.						
P	To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Med	29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signed (Mor	
	F S F O		1 Mochan	1-M2		D-L	10521		January	13,2006
7)	1	30. Name and address of person who cor	npleted cause of death (Item	23а) (Туре,	Print)			U	
			Dr. Mahesh Ochaney	, 325 Hospital	l Dr.,	Glen Bu	cnie, MD.	21061	Suite #20	08
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure	er jo				

		1 - State Amend Item #5	State of Ma						lental Hy	giene Rog. No.	06	00942
\$		Decedent's Name (First, Middle, Last			_,,				2. Date of De Month	eath Day	Year	3. Time of Death
Physicia /Medic		Eleni		Bont	zos				Januar		2006	8:00 P M
Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, To	own, or Loc	ation of Death			County of Dea	th
		305 Powdersby Road				Jop		Under 24 Hrs.	0.0		arford	(2)
Funeral Director		100-40-3332	7. Age	76	Yrs.	If Under 1 Months		ours Min.	8. Date of Bi (Month, Di October	ay, Year)	29 Athe	thplace (State or Foreign ountry) ens, Greece
and *	-	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
ter death with the Marylan Items 23a or 28a-f show Ont must be notified at	ō	MD Harford			Joppa	a						1 ☐ Yes ZX No
the 128s	Director	10e. Street and Number				10f. Zip C	Gode			10g. Citiz	en of What C	ountry?
3a oi		305 Powersby Road				2	1085			USA		
deatl	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.	S. 13. \	Was Deceder	nt of Hispar v Cuban, M	nic Origin? (Sp lexican, Puerto	ecify Yes or No Rican, etc.)	0- 1	4. Race - Am Black, Whi	
72 hours after death with the Maryland natural; or Items 23s or 28s-f show dical Exam, or must be notified.	by Fu	1 ☐ Never Married ※☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:	0		T Yes X		pecify:	,		Specify:	reek
hour tural		15. Decedent's Edi	ucation			dent's Usual				16b. Kir	nd of Business	
- c - 3	Completed	(Specify only highest grad	de completed) College (1-4or 5	+)	(Give life. l	kind of work DO NOT use	done durin retired)	ng most of work	ing			
d with giene pr the	m N	6 years	Sollego (Hou	sewife					1 Home	
s 1 and 2 should be filed within if Health and Mental Hygiens Health and Mental Hygiens of them? I is marked other than other traumatic event, it was	Be (17. Father's Name (First, Middle, Last)						Mother's Nam				
Ment Ment ark	2	Christos Karikas	×1					Asimina				Zio On de l
2 sh and is m		19a. Informant's Name/Relationship (T			ł.	•		Number or Run				nd 21009
1 and Health em 27 ther to		Fotini Kaminaris 20a. Method of Disposition	Daughter	20b. P	ace of Dispo	sition (Name	of		Date		cation - City or	
Pages nent of J int: If its		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,			emetery, cren c Lawn			Janua	ary 2006	Dunc	alk,MD	•
permit. Pages Department of Important: If if any Injury or o		21. Signature of Funeval Service Licens			Č	Name and	Address of	Facility Ho	ome of	Dunda	alk, P.	A. 21222
* 40240		23a. Parri. Enter the disease, or comp	dications that caused	the death				Point			ITK, IND.	Approximate
		shock, or heart failure. List only o	one cause on each lin	θ.								Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a. Meta Due to (or as:			adder	Chrc	er				one month
Examiner					31.22 31,1							
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequ	ience of):							
acuted ind transl	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c									
be executed sician and burial-transit	E	resulting in death, cast	Due to (or as a	a consequ	ience or):							
physicate to the the the the the the the the the the	dlcal	•	d									
eath certific attending p	/Me	IF FEMALE:	23c. If yes, outcome							2	3d. Date of de	olivery
Jeath a atter	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	1 ☐ Live birth 4 ☐ Pregnant at			Ectopic pred Other (spec					Month	Day Year
by the	hys	9 Unknown	9□ Unknown									
The law requires that the death certificate the has been signed by the attending phys page 2 should be detached for use as the	ру Р	Part II. Other significant conditions co	ontributing to death bu	it not resu	ulting in the u	nderlying cau	use given in	n Part I.		tobacco u		o the cause of death?
equir een si sould									10	Yes 2L		,
law r	Completed								24a. Was		24b. Were a prior to death?	utopsy findings available completion of cause of
: The	Co								1 ☐ Yes	2 No	1 ☐ Ye	s 2 No
lcian certifi ector	Be	25. Was case referred to medicat examiner?	Hospitai:				Othor	B. Place of Deat		,		
Physician: The law r this certificate has b ral director, page 2 s	. To	1 ☐ Yes 2 ☑ No 27. Manny of Death	28a. Date of Injur	y	ER/Outpatier 28b. Time of		c. Injury at Work?	4 ☐ Nursing Ho	28d. Describe			ecify)
en ette	tlon	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da)	Year)	Injury	м		2 □ No				
Atten	Certification:	3 Suicide 6 Could not be determined	1	ry - At ho	me, farm, str	eet, factory,	office			(Street and		lural Route Number,
al Dir	Cert	TIOMICOS	Dunding, on	. (0,000,1)								
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After his certificate his completely filled in by the funeral director, page	edical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the best on niner: On the basis of and manner sta	examina	wledge, deat tion and/or in	h occurred a vestigation, i	t the time, on my opinion	date and place, on, death occur	and due to the red at the time	cause(s) , date and	and manner a place, and du	s stated. e to the cause(s)
To th within To th compl	Me	29b. Signature and title of certifier				29c.	License nu	ımber		29d. Date	e signed (Mon	th. Day, Year)
1		1 Leeks	the mo				D63	734		Jan	way 1	7, 2004
		30. Name and address of person who	completed cause of d	eath (Item							J	
)	Ĺ	0 - 1-(3)0-	OI North		ucy (5	cltimo	re "	40 21	231			
Sta Registi		31. Date filed (Month, Oay, Year)	32. Registra	ai s oigna	AS A	Carle Carle	•					

			1- State of Maryland / Departm	nent of Health and Mental Hy cate of Death	/giene 06 00943
	Physic: /Medi		1. Decedent's Name (First, Middle, Last) Essie M. Brady	2. Date of D Month	16 2006 830 P M
	Examir Funeral Director	ner	Levindale 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If U	City, Town, or Location of Death Balto Under 1 Year If Under 24 Hrs. 8. Date of B. (Month, D. 5-5)	4c. County of Death N/A irth ay, Year) -1930 9. Birthplace (State or Foreign Country) N.C.
	aryland show det	Ļ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 t t Yes 2 □ No
	Ba-f	ecto	Md N/A Balto		21
	with the a or 2 ben	ä		Of. Zip Code	10g. Citizen of What Country?
	leath	era	2806 Woodland Avenue 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was I	21215 Decedent of Hispanic Origin? (Specify Yes or N	USA 0- 14. Race - American Indian,
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or itams 23a or 28a-f show or other traumatic avant, the Medical Examinar nust be notified at	Completed by Funeral Director	1 Never Married 2 Married 1 Tyes 2 ThNo	Decedent of Hispanic Origin? (Specify Yes or N , specify Cuban, Mexican, Puerto Rican, etc.) Yes 25x No Specify:	Black, White, etc. Specify: Black
5-0	72 ho	eted	15. Decedent's Education 16a. Decedent's (Specify only highest grade completed) (Give kind	Usual Occupation of work done during most of working Unk	16b. Kind of Business/Industry
121	ne. han	mple	Elementary/Secondary (0-12) College (1-4or 5+)	OT use retired)	State of Md
	filed w Hygien Ather th		12th grade N/A 17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle	Maiden Sumame) TII.
Maryland	2 should be filed withir and Mental Hygiene. is marked other than aumatic avant, ILe M.	To Be	James Conyer	To most or reality (r most mines	Unk
ary	should nd Men marke umatic	F		dress (Street and Number or Rural Route Number	per, City or Town, State, Zip Code)
	1 and 2 Health a em 27 is thar trai		Vonice Brady - Son 811 E	. Belvedere Ave Balto,	Md 21212
Baltimore,	Pages 1 and the part of He int: if item		20a Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition cemetery, cremator, Arbutus Mem	y or other place)	20c. Location - City or Town, State Arbutus Md
Balti	permit. Pag Department Important: i any injury o once.			me and Address of Facility March F/	
	10-73		2.1a. Pp. 1. Enter the disease, or complications that a sed the death. Do not enter the shock, or heart failure. List only one cause on each line.		
	Physician		Included Cause (Final Judges or condition a Cardio Thrombotic ev		Onset and Death
	/Medical		Sulting in death) Due to (or as a consequence of):		
	Examiner	L	Sequentially list conditions, b.		
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or in jury that initiated events		
	xecut and	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):		
68760,	tificate be executed g physician and as the burial-transit	edicai E	d		
	rtifical ng phy as th		IE SCHOOL OF		
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M		pic pregnancy ar (specify)	23d. Date of delivery Month Day Year
	uires that signed b lid be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underly		tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Onknown
Records,	The law require te has been sig age 2 should b	Completed		24a. Wa auto peri 1 ∏ Yes	
Vital	ician: The certificate ector, pag	a)	25. Was case referred to medical	26. Place of Death (Check only	·
of V	hyaich his ce I dìrec	To B		DOA Other: 4 Nursing Home 5 Res	idence 6 Other (Specify)
0 0	ding Phyaician: The h. After this certificate ha funeral director, page		27. Manner of Death 1 ☐ Matural 5 ☐ Pending 28a. Date of Injury 28b. Time of Injury	Work?	how injury occurred
isio	Attand er death ractor: / by the f	icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fa		Street and Number or Rural Route Number,
Division	ai or A s after ai Dirac ed in by	Certification:	4 Homicide determined building, etc. (Specify)		wn, State)
	To the Hospital or Attanding Phyaician: within 24 hours after death. To the Funeral Diractor: After this certifica completely illied in by the funeral director, is	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurrence on the basis of examination and/or investigand manner stated.	urred at the time, date and place, and due to the ation, in my opinion, death occurred at the time.	cause(s) and manner as stated. date and place, and due to the cause(s)
	To the To the comp	ž	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	./		Nist (ajapatiém.D	D0057465	
	り		30. Name and address of pers in who completed cause of death (Item 23a) (Type, Print) N 15 1 KajupauseMD - 25 Main Street, Suite 20	co, keisterstown, MD.	21136
	Sta Registi		31. Date filed (Month, Day, Year) JAN 1 9 2006		

,	,	4	For State Registrar	State of Man		artment of rtificate of			giene 0 0	6 0	094	L.
	Physici		1. Decedent's Name (First, Middle,	BOWE	- 1 \			2. Date of Dea Month	nth Day	Year	3. Time of Dea	
	/Medic	al	CAROLYN 4a. Facility Name (If not institution, g		N	4b. City, Town,	or Location of Deat	JANUAR	4c. County	2.006 of Death	8.49 +	
	LXdiiii		HUNTINON	HOSPITA			11stown			ltimo		
	Funeral Director		5. Social Security Number 6 220–36–5490	A THE STATE OF THE	In yrs. last birthday) 55 Yrs.	Months Days			, Year)	9. Birthplac Country MD		reign
	D		Usual Residence of Decedent 10a. State 10b. County	1/	0c. City, Town or Lo	ocation					I. Inside City Lie	mits
	Manyis	ţ	MD Balti	more	Randall	stown					1 ☐ Yes X☐	XNo
	or 28a	Director	10e. Street and Number			10f. Zip Code		1	10g. Citizen of V	What Country	?	
	ne 23a	erai	4056 Carthage	12. Was Decedent Eve	er in U.S. 13.	Was Decedent of	1133 Hispanic Origin? (5	Specify Yes or No-	14. Rac	S A e	Indian,	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 ie marked other than "neture!", or iteme 23s or 28s-f ehow other treumatic event, its Medical Examinations La notified at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:		If Yes, specify Cu 1 ☐ Yes 2X No	ban, Mexican, Puer o Specify:	to Hican, etc.)	Specify	ck, White, etc $^{\prime:}$ B ${f la}$		
2-0	72 hou	eted	15. Decedent's (Specify only highest	Education grade completed)	(Give	dent's Usual Occu	e during most of wo	rking	16b. Kind of B	usiness/Indus	stry	
121	within iene. than	Completed	Elementary/Secondary (0-12) 12th grade	College (1-4or 5+) 2yrs		DO NOT use retir	ea) C Techni	cal	Social	Secu	rity /	Adm
nd 2	al Hyg d other	BeC	17. Father's Name (First, Middle, La	st)	nee	o an can.	18. Mother's Na	me (First, Middle,	_	ne)		
ryla	should be tand Mental I	2	Charles Steve 19a. Informant's Name/Relationship		19b. Maili	na Address (Stree	Mary I	L. Gask:		State, Zip Co	ode)	
Baltimore, Maryland 21215-0036	and 2 s salth an n 27 le i		Robert Bowen-				ge Road		_			33
ore	ges 1 at of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐Removal from State		matory or other pl	1		20c. Location -			
Ë	permit. Peges Depertment of Inportant: If Ite any injury or of		4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Lie		King Men	norial 2. Name and Add	Park 1/2 ress of Facility /H West	20/06 1	Randal	lstow	n, Md	
Ba	Depe Impo Impo eny tr	-	- varner	Mah	ian 4	1300 Wa	bash Ave			Md	21215	1
Е			23a. Panti. Enter the disease of or shock, or heart failure. List or Immediate Cause (Final	ity one cause on each line.				c or respiratory arr	rest,	In	pproximate nterval Betweer Inset and Deatl	
1	Physician /Medical		disease or condition resulting in death)	Due to (or as a c	MONAR consequence of):					-		
	Examiner		S- juentially list conditions.	0.	TE RE/	VAL	FAILUR	£				
	uted 1 Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a c	OS L	JEPHR	iTis					
, 0	The law requires that the death certificate be executed sie hes been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	i Exa	resulting in death) Last	Due to (or as a c	consequence of):	· · · · · · · ·						
68760,	ficate by physic is the b	edicai		d								
Box (leath certifica ettending pl I for use as t	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2 [⊒Ectopic pregnan	су			te of delivery	av Year	
P.O. E	he dea / the et ched fo	ysici	in the past 12 months? 1 ☐ Yes 2 ☑No 9 ☐ Unknown	4□Pregnant at tim 9□ Unknown	ne of death 5	Other (specify)					.,	
	res that the death igned by the ette be detached for	y Ph	Part II. Other significant condition			inderlying cause g	given in Part I.	23e. Did to	bacco use cont			
ords	w require been sig should b	ted t	DIABETES	MELLITU							ly 4 □Unkn	
Rec	: The law cete hes b page 2 st	mple						24a. Was a autops perfor	med?	Were autops; prior to comp death? 1 □ Yes 2	y findings avail letion of cause	able of
ita		Be Co	25. Was case referred to medical examiner?				26. Place of De	1 ☐ Yes ath Check only or		1 1 1 1 1 1 2 1	ZYNO	
of V	Attending Physician: r death. sctor: After this certificator: by the funerel director.	2	1 Yes 2 No	Hospital: 1 SInpatient 28a. Date of fnjury	2 ER/Outpatie	nt 3LI DOA		Home 5 Resid				
on	nding ath. r: After e funel	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Day Y		W	ork?]Yes 2 ∏No					
Division of Vital Records,	or Atteater designation of the Directo	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		- At home, farm, st (Specify)	reet, factory, office	Э	28f. Location (S City or Tow		er or Rural F	loute Number,	
_	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier (Check only one) Certifying 2 Medical E	Physician: To the best of raminer: On the basis of examiner: and manner state	xamination and/or in	th occurred at the ovestigation, in my	time, date and plac opinion, death occ	e, and due to the curred at the time, c	cause(s) and madate and place,	anner as state and due to th	ed. e cause(s)	
	To the I within 2 To the I complet	Me	29b. Signature and title of certifier				nse number		29d. Date signe			
	ζ,		1	61-1	3		72675		JANUAR	7 11	200	16
	\bigvee		30. Name and address of person w	+COSPITAL S			IRCEA T		DALLSTO	WAV JA	115 CI	133
	Sta Registi		31. Date filed (Mg/th) (Pag. Year)	006 St. Registrar's	s Signature	W						

		-	For State Registrar	State of M		ertificate of		nd Mental Hygi	еле 0 0 6	00945
	Dhusisi		1. Decedent's Name (First, Middle,	Last)				2. Date of Death Month		3. Time of Death
	Physici /Medio Examin	al	Hazel 4a. Facility Name (If not institution,		Lottie	4b. City, Town,	Ball or Location of	Death		26 7 A M
		-	Levindale Nur	sina Home		Balt	imore			
	Funeral Director		5. Social Security Number 227–44–6556	.Sex 7. A	ge (In yrs. last birthda) 68 Yrs.		r If Under 2	8. Date of Birth (Month, Day, O9 26		9. Birthplace (State or Foreign Country) VA
	pu >		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or i	ocation				10d. Inside City Limits
	Aaryle February	ō								1 XYes 2 ☐ No
	the A	rect	MD NA 10e. Street and Number		Baltim	Ore 10f. Zip Code		10	g. Citizen of Wh	at Country?
	h with	i D	5407-5 Wabash	740		2	1215		U.S	Λ
	ems 2	iner	11. Marital Status	12. Was Decedent	Ever in U.S. 13			in? (Specify Yes or No- Puerto Rican, etc.)	14. Race -	American Indian, White, etc.
36	hours after death with the Marylend turei , or items 23a or 28e-f ehow al Examirnar must be notified at	by Funeral Director	X Never Married 2 Marrie 3 Widowed 4 Divorced	If Yes, Give	No	1 ☐ Yes 2 No			Specify:	Black
5-0036	hour turei		15. Decedent's	Year or Dates:	16a. Dec	edent's Usual Occi	upation	1	6b. Kind of Busi	
215	hin 72 in "nei	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or	life.	e kind of work don DO NOT use retir	e during most ed)	of working		
21	ge with	Com	12th grade	lyr		vate Du				mployed
Maryland	should be filed within and Mental Hygiene. e merked other than "umatic event. Its Med	Be	17. Father's Name (First, Middle, La	ist)			18. Mother	's Name (First, Middle, M	laiden Suma m e)	
Z	ould d Men narke natic	2	John C. Ball 19a. Informant's Name/Relationship		10h Mai	ling Address /Stree		tie Mae La or Rural Route Number.		rate. Zin Code)
Ma	d 2 shouth and the and the made treum.									Md 21215
ē,	s 1 and 2 should be filed within 72 hours after death with the Marylen if Health and Mental Hyglene. Item 27 ie marked other than "neturei", or items 23s or 28e-f show other treumatic event. Ite Medical Examples install be invitible 1 at	1	Brenda Boyce- 20a. Method of Disposition	-	20b. Place of Disp	position (Name of	ace)			ity or Town, State
altimore,	Pages ient of nt: if it		1 ☑ Burial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spe	☐Removal from State cify)	,			1/21/06	Randal	lstown, Md
Balti	permit. Pages 1 a Department of Hes importent: if Item any injury or othe once.		21. Signatura i Funeral Service Li	censee A		22. Name and Add March F	ress of Facility			
	₹0.5 € 0	-	2 a. vart1. Enter the disease, or c	U. QU	leg W	4300 Wa	bash <i>l</i>	Ave, Balti		Md 21215
1	Physician /Medical Examiner		shock, or heart failure. List of mediate Cause (Final mease or condition resulting in death)	a	ASTATEC s a consequence of):			Ex Con-s		Approximate Interval Between Onset and Death
(x)	executed n and al-transit	Examiner	Sequentially list conditions, if any, learning to immodule cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	s a consequence of):					
8760	cate be physicies the bur		•	d						
P.O. Box 6	the death certificate be executed y the attending physicien and sched for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 UNo 9 □ Unknown		2 Fetal death 3	□Ectopic pregnan □ Other (specify)	су		23d. Date of Month	,
	requires that the de leen signed by the a hould be detached i	by	Part II. Other significant condition	s contributing to death	but not resulting in the	underlying cause g	iven in Part I.	23e. Did toba	_	ute to the cause of death? Probably 4 □Unknown
Vital Records,	The law ate has b page 2 s	Completed						24a. Was an autopsy perform 1 \(\text{Yes} \)	ad? dea	ore autopsy findings available or to completion of cause of ath?
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital: V		_ 0	thon	of Death (Check only one		
of	Phys rthis ral dir	T.	1 Yes 2 No	1 Inpat		of 28c. Inj	ury at	sing Home 5 Resider 28d. Describe hov		
OU	Attending r death. octor: After	tion	1 Natural 5 Pending Accident investiga	28a. Date of Inj (Month, Date)	ay Year) Injury	W	ork? ⊒Yes 2∐N		. ,	
Division	i or Attendi after death. Director: A In by the fu	Certification:	3 Suicide 6 Could no 4 Homicide determin	4.50	njury - At home, farm, s tc. <i>(Specify)</i>	treet, factory, office	3	28f. Location (Stre City or Town,	eet and Number State)	or Rural Route Number,
_	To the Hospitei or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	edicai C	29a. Certifier (Check only one)	Physician: To the best taminer: On the basis and manner s	of examination and/or	th occurred at the nvestigation, in my	time, date and opinion, deat	place, and due to the car n occurred at the time, dat	use(s) and mann te and place, and	ner as stated. d due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	*			nse number			Month, Day, Year)
	^		sela/f		-30	DZ	376	7	1-1.	3-2006
	3		30. Name and address of person w	HEIDER	no 243	34 W. 15	ELVE	DERE AVE.	BAL	3-2006 TO. AZIZIS
	Sta Registi		31. Date filed (Month, Day, Year) JAN 1 9 2	32 Regis	trar's Signature	Wall by			/	

	_	For State Registrar	State of Maryland		ite of Death		Reg. No.	6 00946
Physicia /Medic	an al	1. Decedent's Name (First, Middle, Last) Lena Bask	kin			2. Date of D Month	10 Day	Year 6 0 0
Examin	C.	4a. Facility Name (If not institution, give : THI - Forest vi i 5. Social Security Number 6. Sep	I e Hulbino 7. Age (In yrs. las	PK FOR	y, Town, or Location of ASTVILL ler 1 Year 11 Under	Md.	4c. County	9. Birthplace (State or Foreign
Funeral Director			M 212√F 90	Yrs. Month	s Days Hours	Min. (Month, D 08 0	ay. Year) 7 15	South Carolina
Ba-f show	Director	10a. State 10b. County MD Prince Ge		Town or Location				10d. Inside City Limit
23a or 2	ai Dire	10e. Street and Number 7420 MArlboro Pi	ke		Zip Code 20747		10g. Citizen of V	What Country?
atural', or freme 23e or 28e-f e-how ical Examinat must be notified at	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	If Yes, sp	edent of Hispanic Ori pecify Cuban, Mexicar 2図 No Specify:		Blac	ce - American Indian, ck, White, etc.
piene. r than "natural!, the Medical Exc	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	16a. Decedent's Us (Give kind of v life. DO NOT	vork done during mos	st of working	16b. Kind of B	usiness/Industry
od othe	To Be Cor	8th. 17. Father's Name (First, Middle, Last) Willie Moore		Laundr	18. Mothe	er's Name (First, Middle	e, Maiden Suman	m Hotel
e ma	Ė	19a. Informant's Name/Relationship (Ty Sandra P. Paytor		3	ss (Street and Number	er or Rural Route Numb	er, City or Town,	
if Item 2 or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State 20b. Pla	ce of Disposition (A netery, crematory o	lame of r other place)	Date	20c. Location -	City or Town, State
Important: any Injury o		21. Signature of Funeral Service License			and Address of Facilit	1-13-06 ^N Marshall' N.W. Washir	s Funer	
physicien and ledical transit the burial-transit	ai Examiner	23a. Party Ender the disease, or compliance. List only or timediate Cause (Final disease or condition resulting in death) Social thing fet monditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indited events resulting in death) Last	ne cause on each line.	CERDT C nce of):	CARDION		DisGA.	Interval Between Onset and Death
by the ettending phys teched for use as the	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome st pregnand 1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea	eath 3□Ectopic				te ol delivery nnth Day Year
been signed by	þ	Part II. Dther significant conditions cor	ntributing to death but not result		cause given in Part I		W 111	nbute to the cause of death? 3 Probably 4 Unknow
page 2 sho	Completed						ormed?	Were autopsy lindings available prior to completion of cause of death? 1 □ Yes 2 □ No
rector	o Be	25. Was case referred to medical examiner? 1 Yes 2 10	fospital: 1 ☐ Inpatient 2 ☐ El	P/Outpatient 3	Othor	ol Death (Check only ursing Home 5 ☐ Res		or (English
I Director: After this d in by the funeral di	Certification; T	27. Manner of Death 1 Matural 2 Accident 3 Suicide 4 Homicide		8b. Time of Injury M	28c. Injury at Work?	No 281. Location	how injury occur	
Funere ely fille	edicai Ce	29a. Certifier 1 Certifying Physical Check only 2 Medical Exami	sician: To the best of my knowl ner: On the basis of examinatio and manner stated.	edge, death occurrent and/or investigati	ed at the time, date an	nd place, and due to the th occurred at the time	cause(s) and ma date and place,	anner as stated. and due to the cause(s)
To the Complet	Me	29b. Signature and title of certifier	ATTENDING P		29c. License number 52	900		d (Month, Day, Year) 2006
			ompleted cause of death (Item 2	<u>_</u>				

	•	Amend item#2			,		tificate					Reg. No	11111	5	009	47
Physicia /Medic		1. Decedent's Name (Fin		e Buttne	r						2. Date of D Month Januar	Da		Year 06	3. Time of 3:55	of Death
Examin Funeral Director		4a. Facility Name (If not a Maples of 5. Social Security Number 216-07-531.	Towson er 6. Sex	treet and number)	e (In yrs. last b	iirthday) Yrs.	4b. City, T	Tow	Location SON If Under Hours		8. Date of B (Month, D May 2	irth ay, Year,	Ba	of Death 1tim 9. Birth Cou		
and w		Usual Residence of Deci			10c. City, To	wn or Lo	cation								10d. Inside (City Limits
r 28a-f ahow	tor		Baltimore		Tow	son										s 2 No
ith the or 28s	lrec	10e. Street and Number			1		10f. Zip (Code				10g. Ci	itizen of W	hat Cou	ntry?	
23a c	rai	7925 York							204				USA			
5-0036 72 hours after death with the Maryland natural; or Items 23a or 28a-1 ahow altest Examinat must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 3 ☐ Widowed 4 □	2 Married	I2. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:			Vas Decede Yes, specr		ispanic Or in, Mexica Specify		ecify Yes or N Rican, etc.)	0-		, White		
	Completed	15. (Specify or Elementary/Secondary	Decedent's Edu nly highest grade y (0-12)	cation completed) College (1-4or		(Give	ent's Usual kind of work OO NOT use	done o	durina mos	st of work	ing	16b. F	Kind of Bus	siness/Ir	ndustry	
nd 212 a filed within il Hygiene. other than	S	17. Father's Name (First	Middle Last)	n/a		Hom	emake	er	19 Moth	er's Nam	e (First, Middle	a Maida			ome	
ylanc ould be fi Mental P arked of	o Be	Philop Blot		er							Ramer	o, maioer	n Jonaine	'/		
re, Maryland 2121 s 1 and 2 should be filed within Health and Mental Hyglene. Item 27 Is marked other than other traumatic avant. The Ma	၉	19a. Informant's Name/I			19	b. Mailin	g Address	(Street			al Route Numi	ber, City	or Town, S	State, Zij	code)	
		Sandra Mu	rrev/nic	ece	1	4603	Old	Yo	rk R	d.,	Phoeni	×, M	D 21	131		
Baltimore, permit. Pages 1 at Department of Hea Important: If Item any Injury or oths		20a. Method of Dispositi 1 X Burial 2 ☐ Cre 4 ☐ Donation 5 ☐	ion emation 3 □R			егу, степ	sition (Name natory or oth	her plac			Date 7 / 06		ocation - C	00000	own, State	
Balti permit. Departn Imports any Inju		21. Signature of Funeral	Soco Lipons	Ø		22	. Name and	Addres	s of Facil	ity			35		lass L	
n goesa		Michael	J. Flag			10	W. F	ado	nia	Rd.,	ome of Timor	nium,	, MD	210	193 I	nc.
Physician /Medical Examiner		23a. Part1. Enter the dis shock, or heart fail Immediate Cause (Final disease or condition resulting in death)	lure. List only or	cations that cause to cause on each li	a consequence	r le	or the mode	. ^ .	g, such as		or respiratory	arrest,		1	Approxima Interval Be Onset and	etween
18760, cate be executed physician and the burial-transit	edical Examiner	Sequentially list condition if any, leading to immediate. Enter Underlying Cause, (Disease or injury that initiated events resulting in death) Last	ons, diate g	. Due to (or as	a consequence										2 /	ars
P.O. BOX 6 nat the death certifi d by the attending.	Physician/Medical	IF FEMALE: 23b. Was decedent predinthe past 12 moni 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ths?	3c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Fetal deat		Ectopic pre Other (spe						23d. Date Mont		ery Day	Year
Cords, P	þ	Part II. Other significant	t conditions con	stributing to death t	out not resulting	in the ur	nderlying ca	use give	en in Part	l.					he cause of bably 4	
of Vital Records, Physician: The law requires t rthis certificate has been signe rrai director, page 2 should be o	Completed	Chroni	e Ur	hyth k	Trac	r i	n Je	241	DW.			opsy formed? _	pr	ere auto for to co ath? Yes	opsy findings ompletion of a	available cause of
Vital Pysician: Thysician: The is certificate director, pag	Be	25. Was case referred to examiner?	117	lospital:		- 17		Oth			h Check only				Anni	1.1
ding ding Afte	ation: To	1 Yes 22 No 27. Manner of Death 1 2 Natural 5 2 Accident	Pending	28a. Date of Inju		Outpatien Time of Injury		c. Injun	4014		ome 5 □ Res 28d. Describe				M) (1) (M)	ving
in Piete	Certification:	4 Homicide	Could not be determined	13317	ic. (Specify)	ing	Faci	111-	+			own, Stat	'e)			n <i>ber</i> ,
Hospital Pours a Funeral I	Medical	29a. Certifier 1 2 (Check only 2)	Gertifying Phys Medical Exami	sician: To the best ner: On the basis of and manner st	of examination a	ge, death ind/or inv	occurred a restigation,	it the tin	n, date a pinion, de	nd place, ath occur	and due to the red at the time	e cause(s e, date an	s) and man nd place, a	ner as s nd due t	stated. o the cause(s)
To the within 2 To the complete	Med	29b. Signature and title	of certifier		V)		29c.	Licens	o number	48	5	29d. Da	ate signed	(Month,	Day, Year)	
'n		30. Name and address of	of person who co	mpleted cause of	death (Item 23a) (Туре,	Print)	0	. 70		sler D			2120	04	100

State of Maryland / Department of Health and Mental Hygiene () 00948 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Helen Louise Brown 2:15 A.M 18 2006 January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Sykesville Carrol1 Continuum Care At Sykesville 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 XF 94 Yrs. 217 22 3975 3Ó, 1911 Maryland Director Usuat Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location wode 10a. State rthen "naturel", or Items 23s or 28s-1 showing the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Director Carrol1 Eldersburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S. Rudy Serra Drive 21784 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status hours efter 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 □Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) nd 2 should be filed within 7 slth and Mental Hygiene.
27 ie marked other then "r rraumatic event, the Men Elementary/Secondary (0-12) / th College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mane King William Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Depertment of Health at Important: if item 27 ie ony injury or other trau Gilbert Brown / Son Millersville, Maryland 21108 339 Overcup Court Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park 1/21/2006 Glen Burnie, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Fugeral Service Licenses 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the de Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Onemonia one veek. **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consquence of physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical ettending pl IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) Ö certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Dunknown ۵, Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes autopsy perform 1 ☐ Yes 2 ☐ No 2 No Division of Vital : After this certifical funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturat To the Hospitel or Attending within 24 hours effer death.
To the Funerel Director: Afte completely filled in by the fune 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00059943 18,2000 30. Name and address of par on who complet cause of death (Item 23a) (Type, Print) John (Assel Mo Strev AR 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIĞINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 005 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Month 00 **Physician** Ам 12006 Alvenia Muary /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Eacility Name (If not institution, give street and number) **Examiner** Raltimore Nursi no Haven Year If Under 24 Hrs. Days Hours Min. torest 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Days **Funeral** 1 M 2 F Months Ayust/6,191 138-15-0674 Director Usual Residence of Decedent 10d. Inside City Limits deeth with the Maryland 10c. City, Town or Location 10a. State 10b. County item 27 is marked other then "natural", or items 23e or 28e-f show other treumstic event, the Medical Examiner must be inclified at 1 Yes 2 No Baltimore Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Avenue 0515 Stonington Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural; or lien any injury or other traumatic event, the Madical Examinar 2008. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Black Baltimore, Maryland 21215-0036 Specify Completed by 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Coat Factory eamtress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Brown Washington mar ဂ္ ames Anderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bultimone MD 21207 Avenue Owes/Davghter Stonington 5713 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Naurial 2 Cremation 3 Removal from State Rolling Greenmem. PK January 19, 2006 West Chester, PA 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Hari, P. Cluse Funeral Service, P.A.
5126 Belana Road, Baltimone, MD 21206 21. Signature of Fune al Service List nsee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. Approximate Interval Between Onset and Death ATHEROSCLEROTIC Immediate Cause (Final disease or condition resulting in death) CEREBROVASCULA EASE Physician /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to for as a consequence off Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown been signed by t should be detach Part II., Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 ☐ Yes 2 No 1 Yes 2 No certificate To the Hospital or Attending Physicien: To within 24 hours after death.
To the Funerel Director: After this certifical 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No Nursing Home 5 Residence 6 Other (Specify) ္ပ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred in by the funeral 28b. Time of 27. Manger of Death Certification: Natural 5 Pending 1 🗌 Yes 2 🗆 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Турф, Print) 1 ASNEEM 7220 TARK 2. Registrar's Signature 31. Date filed (Month, Day, Year) State 9 2006 JAN 1 Registrar

		01	1 - For State Registrar	State of M	aryland		artment of F rtificate of		d Mental H	lygiene Rag. No	71116	00950
	Between		1. Decedent's Name (First, Middle,	Last)					2. Date of Month	Death Da	y Year	3. Time of Death
	Physici: /Medic		DOROTHY	2		BRI	my		TANK		7, 200	1 /05 CL / M
).	Examin		4a. Facifity Name (If not institution,	give street and number	7)		4b. City, Town, o	r Location of D	Death	4c	. County of De	ath
			NORTH WEST	HOSPITA	H			PALLSTA			BALTI	more
	Funeral				ge (In yrs. la	* .	ff Under 1 Year Months Days		Hrs. 8. Date of Month,	Birth Day, Year)	9. B	irthplace (State or Foreign Country)
	Director		199-09-7018	1 □ M 2 💢 F	86	Yrs.			07/1	Day, Year) 6/19	19 PI	ENŃŚYLVANIA
	D .		Usual Residence of Decedent		100 City	. Town or Lo	estion					10d. Inside City Limits
	aryla ahov	_	10a. State 10b. County	-1/077	1							1 □ Yes 2 □ No
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	vith ti	Director	10e. Street and Number				10f. Zip Code	0.7			tizen of What (Sountly?
	ath v	rai	6825 CAMPFIE		. 6	140.1	212		2 (Canada Van as		SA	nerican Indian,
	er de	Funeral	11. Marital Status	12. Was Deceden Armed Forces	i?	5.	Was Decedent of I If Yes, specify Cub	an, Mexican, P	Puerto Rican, etc.)	140-	Black, Wh	
36	s aft	by F	1 ☐ Never Married 2 ☐ Marrie 3 🛣 Widowed 4 ☐ Divorced	ed 1 ☐ Yes 2 🖫 If Yes, Give Year or Dates			1 ☐ Yes 2 📉 No	Specify:			Specify:	VHITE
8	within 72 hours after death with the Maryland ene. than "naturel", or items 23s or 28s-f show he Medical Examiner must be notified at	pa	15. Decedent			16a. Dece	dent's Usual Occup	pation		16b. K	(ind of Busines	
5	in 72	jet	(Specify only highest	t grade completed)		(Give	kind of work done DO NOT use retire	during most of	working			
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D	Hyg other	BeC	17. Father's Name (First, Middle, L	ast)				18. Mother's	Name (First, Mid	dle, Maider	Sumame)	
Maryland	id be ked ked	To B	ALBERT EMBLE	TON				BESSI	IE WHEA	\mathtt{TLY}		
a _Z	shound N		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailir	ng Address (Street	and Number o	or Rural Route Nu	nber, City	or Town, State	, Zip Code)
Ξ	alth a		RUSSELL C. B	ROWN JR.(SON)	5413	PRINCE	SS DR	BALTO	.,MD	. 2123	37.
ē,	other		20a. Method of Disposition			ace of Dispo	sition (Name of matory or other pla	ca)	Date	20c. L	ocation - City	or Town, State
Ē	Page Bent of Int: If		1⊠Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp						01/21/	2006	TIMON	NIUM, mD.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelih and Mental Hygiene. Depertment of Heelih and Mental Hygiene. Important: If Itam 27 Is marked other than "natural; or itama 23a or 28a-f ahow always injury or other traumatic avent, the Medical Examiner must be notified at ance.		21. Signature of Funeral Service	icensee	11		2. Name and Addre			0110	20	
m	Depermine Depermine Impo		Willer	Cauda		H.	ENRY W. 6924 YO	RK RD	LNS & S MONKTO	ONS (. 2111	1.
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that cause	ed the death							Approximate Interval Between
	Physician		fmmediate Cause (Final	only one sause on saun								Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or a	is a consequ	ience of):						any
	Examiner				1 est	easton	Lande					days
		Jer	Sequentially fist conditions, if any, leading to immediate	Due to (or a	s a consequ	ence of)	Jarle					0
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ó	en er en er irial-t	EX	resulting in death) Last	Due to (or a	is a consequ	ience of):						
8760,	death certificete be executed estending physicien end ad for use as the burial-transit	icai		d								
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Вох	eath certific ettending p	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1☐Live birth		death 3	Ectopic pregnanc	у			23d. Date of d Month	lelivery Day Year
-	he et	Sici	1 ☐ Yes 2 ☐ No	4□Pregnant 9□ Unknown		eath 5	Other (specify) _			- [,
0	of the	Physician/Med	9° Unknown	na	but not soon	. Itima in the	andrah ilan sawas ar	von in Bart I	230 0	occedet bi	use contribute	to the cause of death?
	law requires thet the de as been signed by the e 2 should be detached f	۵	Part fl. Other significant condition	vis contributing to death	DOL HOL 1950	illing in the d	indenying cause gi	voirin Paiti.		☐ Yes 2		Probably 4 Munknown
ecords,	w require been sign	Completed							- '	1	1110	, research
9	has b	pje							24a. W	has an utopsy arformed?	prior t	autopsy findings available o completion of cause of
œ	The page	S							1 □ Ye		death 1 □ Y	
Vital	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			. 0	hom	Death (Check or			
f	this c	ဥ	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 X Inpa		ER/Outpatie 28b. Time o	nt 3 DOA	4 Nursi	ing Home 5 ☐ R			pecify)
Ĕ	a fe	io	1 ⊠Natural 5 ☐ Pending		Day Year)	Injury	Wo	rk?]Yes 2 ☐ No		56 110 W 11170	ny occurred	
S	a train	cat	2 Accident investig 3 Suicide 6 Could r	not be 300 Place of t	tojuni - At ho	me farm et	reet, factory, office	7.03 2		n (Street a	nd Number or	Rural Route Number,
Division of	al or Attandi s efter death. ii Diractor; A ad in by the fu	Certification:	4 Homicide determi		etc. (Specify		ibbi, lacioty, office			Town, Stat		
_	To the Hospital or Atti within 24 hours efter de To the Funeral Directo completely filled in by ti		29a. Certifier 1 Certifyin	g Physician: To the be	st of my know	wledge, deat	th occurred at the t	me, date and	place, and due to	the cause/s	and manner	as stated.
	24 h	edicai		Examiner: On the basis and manner	of examinat							
	To the within To the comple	Me	29b. Signature and title of certifier				29c. Licen	se number		29d. Da	ate signed (Mo	onth, Day, Year)
	F ≤ F 5		> ~		0		2	00597	73/	Ja	newy 1	7, 2006
	(i)		30. Name and address of person	who completed cause of	f death (Item	23a) (Type.		103 1	76			1
Y	N/			mateen m		4.5		SPITAL	5401	oun	cour	- RUAD
	Sta	ite	31. Date filed (Month, Day, Year)	32. Regis	strar's Signa	ture						
	Regist	rar	JAN 1 9 2	006	N. A.	15/12	ASEA					

Registrar

State

31. Date filed (Month, Day, Year)
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9 2006

KURET

32 Registrar's Signature

111 Penn Street Baltimore, Maryland 21201

.000)		1 - For Stata Registrar	State of Mar	-	Departme <i>Certifica</i>			nd Me		ene ()	06	009	52
Dhyoid	ion	1. Decedent's Name (First, Middle, La	st)						Date of Death Month	Day	Year	3. Time of	
Physic /Med		CHARLES A. BYRD							January	01	2006	6:12	РМ
Exami	iner	4a. Facility Name (If not institution, giv					r Location of	f Death			nty of Death		
		Washington Count 5. Social Security Number 6.5		In yrs. last bin		ersto	WIN If Under 2	4 Hrs.	R Date of Righ	1	ington		or Foreign
Funera Director			M 2□F	10	Yrs. Month		Hours	Min.	8. Date of Birth (Month, Day, 2–23–198	Year) 27	MARY	lace (State o try) T AND	ii roreign
		Usual Residence of Decedent							2-23-170		1121111	DIND	
yland how		10a. State 10b. County	1	Oc. City, Town							1	0d. Inside Ci	
e Ma	cto	MD. N/A		BAL	TIMORE							1 X XYes	2 NO
ارة 12 ع	Dire	10e. Street and Number			10f. i	Zip Code			10		of What Coun	try?	
ath w	rai	130 REEDBIRD AV	T T		140 W - D	2122		:-2 (0	-t. Va a a Na	US.	A lace - Americ	an Indian	
ltem	une	11. Marital Status 1 ☑ Never Married 2 ☐ Married	12. Was Decedent Ev Armed Forces? 1 □ Yes 2 ☑ No	er in U.S.	If Yes, s	pecify Cuba	an, Mexican,	Puerto R	cify Yes or No- lican, etc.)		Black, White,		
urs at	by Funeral Director	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 Tes	2X No	Specity:			Spe	city: BL	ACK	
ITTID-UUSD within 72 hours after death with the Maryland ene. then "naturel", or Items 23a or 28a-f ehow he Medical Examinar must be invitiled at	Completed	15. Decedent's E (Specify only highest gr	ducation	16a.	Decedent's U (Give kind of	sual Occup	ation	of workin	NWK 1	6b. Kind of	Business/Inc	dustry UN	IK
thin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NOT	use retire	d)	OI WORKIN	9 17				
d Z1 filed wi Hygien other th	Co	_9_	-0-				40.44-15	4- N	Fire Middle M	-14 0			
ire, Maryland Z1Z13-0030 s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 Is marked other then "naturel", or Items 23a or 28a-1 show other treumatic event, the Medical Examplar must be invititied at	To Be	17. Father's Name (First, Middle, Last CHARLES A. BYRI							(First, Middle, M. COVING		атө)		
Maryland 21215-UU30 nd 2 should be filed within 72 hours at the and Mental Hygiene. 27 Is marked other than "naturel", or renumatic event, the Madical Exert	-	19a. Informant's Name/Relationship		19b	•				Route Number,				
and and m 27		ANGELA BYRD(MOT	HER)	20h Blass st			D AVE.		TIMORE,				
Saltimore, permit. Pages 1 ar Department of Hea Importent: If item eny injury or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 [cemeter	f Disposition (f ry, crematory o	r other plac			_		n - City or To		
ti Pa ti Pa ritmen ritent:		4 Donation 5 Other (Special Signature of Function 1)			CREMAT						ORE, M		1D
Baltimorr permit. Pages : Department of P Importent: If its eny injury or or		21. Signature of Potostal Service Lice	JUNATHAN HUSAN	שות. ח					T. BALT				21217
If be executed We sicion and with the surface of t		shood, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a control of the co	consequence	or):	Cav rode	nii	Pn-cy 1	lival I	ia nfect	ion	Interval Bet Onset and I	
I HECOTGS, P.O. BOX 68/6U, The law requires that the death certificate be executed the has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	☐Fetal death	3 ⊟Ectopic 5 ⊟ Other		y				Date of delive		Year
dS, P		Part II. Other significant conditions	contributing to death but	not resulting i	n the underlyin	g cause giv	ven in Part I.		23e. Did toba	accouse co		_4,	death? Unknown
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	BeC	25. Was case referred to medical examiner?						of Death	(Check only one)			
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on or vita ding Physician: n. After this certific funeral director,		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b.	Time of Injury	28c. Inju	_		8d. Describe how	v injury occ	curred		
VISIC Attent r deati ector: by the	Certification:	2 Accident investigation 3 Suicide 6 Could not lead to determined 4 Homicide determined	De 200 Place of Injur	y - At home, fa (Specify)	M arm, street, fac		Yes 2 □ t		8f. Location (Stre City or Town,	eet and Nu State)	mber or Rura	l Route Num	iber,
Hospital or 124 hours after Funaral Directory filled in letely filled	edical C		hysician: To the best of e miner: On the basis of e and manner state	xamination an									;)
To the within 2 To the complet	₹	29b. Signature end title of certifier				29c. Licens	se number		29	d. Date sig	ned (Month,	Day, Year)	
		Derver H	llann	d			CME		J	anuar	y 2, 2	006	
)		30. Name and address of person who	completed cause of dea	ath (Item 23a)	(Type, Print)		Andrew Charles					H-MW-	
		CAROL HA	CHANA			111 E	enn S	treet	Balti	more,	Mary1	and 21	1201
S Regis	tate	31. Date filed (Month, Day, Year)	32. Registrar	's Signature	Acres 2	: 19							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year /Medical 06 4a. Facility Name (If not institution, give street and n 4b. City, Town, or Locetion of Death Examiner 4c. County of Death NURSING ILLENIUM If Under 1 Year If Under 24 Hrs. N/A Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 214-20-3598 Usual Residence of Decedent 1 □ M 2 F Months Days Hours Director 2-12-1912 NORTH CAROLINA parmit. Pages 1 end 2 should be filad within 72 hours efter death with the Marylend Dapertment of Haalth and Mental Hygiene. Important: If Item 27 is marked other then "natural", or items 23e or 28e-f show any injury or other traumetic event, I'm Medical Examinat LAMS be notited at 10a. State 10b. County r then "natural", or items 23e or 28e-f show 10c. City, Town or Location 10d. Inside City Limits Director MD. N/A BALTIMORE 1 ☑ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2404 FEDERAL ST. 21213 USA 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give X 1□Yes 2₺No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Specify: BLACK Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSEKEEPING DOMESTIC 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) MARK HUNTER ٩ CLORIA HUNTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARTHUR BELLAMY (SON) 2975 MONMOUTH RD. JOBSTOWN, NEW JERSEY 08041 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State NBurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation /5 ☐ Other (Specify) MT. ZION CEMETERY 1-12-2006 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee JONATHAN D. HIBNER Name and Address of Facility REDD FUNERAL SERVICE 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part1 — her the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** Metastatie Concer primary NOT /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner l or Attending Physician: The law raquiras thet tha death cartificate ba executad buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last and Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, signad by tha ettanding physiclan I ba detechad for usa as tha burie Physician/Medical tha Due to (or as a consequence of): for usa Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown <u>ک</u> Be Completed 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 12 No 1 ☐ Yes 2 ☐ No funaral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: r death. Medical Certification: To 1 Yes 2 No Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28e. Date of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Director: A 2 Accident 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) complately filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 2006 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) MD -AHMED Ellaw 821 Nº 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar **DHMH 16 Rev 6/95**

			Chate of Manuford / Department of Health and	•	_	
			State of Maryland / Department of Health and		7 1110	00954
_	-		Registrar Certificate Of Death	Reg.	No."	0000
). Dhuaisi		1. Decedent's Name (First, Middle, Last)	Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		PAULINE FRANCELLA COBB BRODIE	January	17, 2006	9:00 A
()	Examir		4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deat	h	4c. County of Death	
			HOSPICE OF BALTO:GILCHRIST CENTER Towson		Baltimore	County
10	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min.		9. Birthi	place (State or Foreign ntry)
1	Director		220-20-3032 1 M 2 F 79 Yrs. Months Days Hours Min.	Nov 13, 1		yland
1	pu 💃 😅		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			I0d. Inside City Limits
	arylan ahow	5				1 ☐ Yes 2 🔀 No
2	the Market 1	Sct	Maryland Baltimore County Parkville	100	Citizen of What Cou	
AM	death with the Maryland ms 23s or 28s-f show must be notified at	Funeral Director	10e. Street and Number 10f. Zip Code	log.		III y r
0	ath v	rai	8820 Walther Boulevard, #4309 21234	Sanata Van ar No	USA 14. Race - Ameri	nan Indian
1	er de	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	Black, White,	
ഴ ജ	rs att	by F	1 Never Married 2 Married 1 Yes 2 No If Yes, Give X 1 Yes 2 No Specify: Year or Dates:		Specify: W	nite
- 5 등	within 72 hours atter death with ene. then "naturel", or items 23e or the Modical Examiner must be	edi	A 15 Decedent's Education 16a Decedent's Usual Occupation	16b	, Kind of Business/In	dustry
15	in 72	olet	(Specify only highest grade completed) (Give kind of work done during most of wo	rking Ba	altimore (County
77	within iene. then	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 1 Secretary	Be	oard of Ed	lucation
Paulin	Hyg Hyg other	O	17. Father's Name (First, Middle, Last) 18. Mother's Name	me (First, Middle, Maid	den Surname)	
an	d be entel	To Be	Cobb		(Carter
e_{j} $f_{a}uline$ Maryland 21215-0036	2 should be tiled v and Mentel Hygie i in marked other t rsumatic avent, th	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ri	ural Route Number, Ci		
S P	s 1 and 2 should be tiled within 72 hours atter death with the Maryla f Heelth and Mentel Hygiene. It was 23 or 28s-1 and tem 27 is marked other than "natural", or items 23s or 28s-1 ahouther trsumatic avent, the Madical Examinar must be notified at		Melissa B. Richardson (Daughter) 8430 Governors Run,	Ellicott (City. Mary	land 21043
je,	of Heelth item 27		20a. Method of Disposition 20b. Place of Disposition (Name of	Date 200	. Location - City or T	own, State
30	Pages nent of I int: if it		1 □ Burial 2 ▼Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Green Mount Crematory 1/	18/2006 Ba	1timore 1	Marvland
3 rod, Baltimore,	artm ortar injur		21. Signature of Funeral Serva Light 22. Name and Address of Facility	10/2000 Da	ICIMOTC, I	RITTERR
B B	permit. Pages Department of Important: if it any injury or o		21. Signature of Funeral Serves Cice and Address of Facility Martin D. Lawson 22. Name and Address of Facility Mitchell-Wiedefe 6500 York Road, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.	ld Funeral	Home, Inc	21212
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia	c or respiratory arrest,	ralylan	Approximate Interval Between
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ω.	deat	Sicien	In the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		Month	Day Year
P.O.	by the	츳	9 LJ Unknown		L	
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<u>></u>	ysici s cer direc	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing 8	Home 5 Residence	e 6 Other (Speci	y) Homse
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<u>.</u>	ndin ath. r: Att	atio	1 □Natural 5 □ Pending (Montul, Day 1981) Illyury (101) 2 □ Accident investigation M 1 □ Yes 2 □ No			
vis Vis	Atta ecto by th	II C	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S	t and Number or Run tate)	al Route Number,
ā	taior s ette al Dir	Certification;				
	To the Hospital or Attanding Physicien: The law requires that the death certificate within 24 hours elter death. Within 24 hours elter death. To the Funeral Director: After this certificate has been signed by the attending physicompletely titled in by the tuneral director, page 2 should be detached for use as the	edical	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occ	e, and due to the caus urred at the time, date	e(s) and manner as s and place, and due t	stated. o the cause(s)
	the P the P nplete	Med	one) and manner stated. 29c. License number	294	Date signed (Month,	Day Year)
	To To	-	230. Signature and the or comment			
	†		1/	7	100071	/
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	St. Bal	to. md ?	21205
			31. Date filed (Month, Day, Year) & 32. Registrar's Signature			
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			For State Registrar		Marylan		rtment tificate					Reg. No	006	009	55
	Physicia	an	1. Decedent's Name (First, Middle, Las								2. Date of De Month	ath Day 17	Year		Death P M
	/Medic Examin		Grace Eugenia Cefal 4a. Facility Name (If not institution, give		nber)		4b. City, 1	Town, or	Location o		anuary		2006 County of Dea		Ρ
	Examili	e:	5617 Gardenville Ave	nue			В	altim	ore				N/	'A	
橡	Funeral Director			x □ M 2[X F	7. Age (In yrs. 86	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da 01/23/19	th 19 Year)		nthptece (State of Juntry) JIMORE, MD	_
	land		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside Ci	ty Limits
	Mary B-1 ah	tor	Maryland N/A			Balt	imore							1 🔀 Yes	2 □ No
	h with the 23a or 28 at be not	al Director	10e. Street and Number 5617 Gardenville Aven	ue			10f. Zip 2	Code 1206				10g. Citiz Uni t e	en of What C	ountry?	
20	d within 72 hours after death with the Maryland jiene. I than "natural", or items 23a or 28s-f ahow I're Macical Examirati wat be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married	Armed Fo 1 Tes If Yes, Giv	0	1	Was Decedi f Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spec , Puerto R	cify Yes or No lican, etc.)		4. Race - Am Black, Wh Specify: Wh		
Š	thours stural	ed b	3X Widowed 4 □ Divorced 15. Decedent's Ed	Year or Da	ates:	16a. Deced	lent's Usua	I Occupa	tion				d of Busines:		
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saitimore,	Pages 1 nent of H int: If ited ury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		State	Place of Dispo semetery, cren kwood Ce	natory or ot	her place)1/21/2	2006		ation - City o	Maryland	
Balt	permit. Pages. Department of Inportant: If ite any injury or of other		21. Signatur & Funerar Service Licen	se Charles	F. Mine	155	. Name and				5305 Har Baltimor			21214	
8	9.5		23a. Part1. Epper the disease, or composhock, wheart failure. List only	olications that cone cause on e	aused the deat ach line.	h. Do not ent	er the mode	e of dying	, such as	cardiac or	respiratory a	rrest,		Approximat Interval Bet Onset and I	ween
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O. Box 6	death certi e attending od for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		irth 2 ☐ Feta ant at time of d	Ideath 3	Ectopic pro		-			2	3d. Date of de Month	,	/ear
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	Physici this cer al direct	To B	examiner? 1 Yes 2 No			ER/Outpatien			r: 4 □ Nu		ne 5 ☑ Resi	-	□Other (Sp	ecify)	
lon of	ling After		27. Mann of Death 1 Natural 5 Pending 2 Accident investigation		of Injury h, Day Year)	28b. Time of Injury	M 2	8c. Injury Work 1 🗌 Y	at ? ′es 2 □ !		8d. Describe	how injury	occurred		
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	To the Hospital within 24 hours at To the Funeral D completely filled in	edical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	iner: On the b	best of my kno asis of examina ner stated.	owledge, death ation and/or in	occurred a	at the tim in my op	e, date and inion, deal	d place, ai th occurre	nd due to the d at the time,	cause(s) date and	and manner a place, and du	is stated. e to the cause(s)
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-	0		1 Harry	my co				V L	63	+		1/1	8/06		
5			Barry Joseph		760	0 0sle	•	ve	Suite	311	Tows	son,	MD 21	204	
1	Sta Registr		31. Date filed (Month, Day, Year) JAN 1 9 2006	32. R	egistrar's Signa	ature (7								

		-	For State Registrar			d / Depa		of H	ealth an	d Mentai I	Hygie Reg.	1	006	009	56
	Physicia	an	1. Decedent's Name (First, Middle, L	EDWARD	3		C	OLE		2. Date o Month		Day	Yeer	3. Time of 9:00	Death A M
9	/Medic Examin		4a. Facility Name (If not institution, gi 3702 Fourth Str	ve street and numb	Der)	•	4b. City, T		Location of D	Janua	ary .	4c. C	2006 Sunty of Dec N/A		A
434	Funeral Director		220-22-6532	Sex 7. 1⊠M 2□F	Age (In yrs. 76	last birthday) Yrs.	If Under Months	Days	If Under 24 I Hours A	Hrs. 8. Date of (Month) Apr	Birth Day, Ye	192	9. Bii O Ma	rthplace (State of ountry) aryland	or Foreign
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland N/A		10c. Cit	y, Town or Lo	ocation	Вг	ltimor	e				10d. Inside C	ity Limits
	th with the 23s or 28s	ai Director	10e. Street and Number 3702	FOURTH	STREET		10f. Zip	Code	2122	5	10g.	Citize	n of What C	ountry?	
036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural; or items 23a or 28a-f show other traumatic avent, the Medical Exercities is use be notified at	by Funerai	11. Marital Status 1 □ Never Married 2 → Married 3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 2 Yes 2 If Yes, Give Year or Date	es? No		Was Decede If Yes, speci 1 Yes 2			(Specify Yes o uerto Rican, etc.	r No-)		Race - Am Black, Whi becify:	encan Indian, ite, etc. White	
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and	d be file antal Hy sed oth c avent	Be	17. Father's Name (First, Middle, Lasunknown	<i>t</i>)			Cole		Janni	Name (First, Mic E Lo	_{idle, Mai} Dwmar		imame)		
Baltimore, Maryland 21215-0036	nd 2 should lith and Men 27 is marke r traumatic	၉	19a. Informant's Name/Relationship Mrs. Jean Cole		(wife)		ng Address			Rural Route Nu altimor					
ore,	ges 1 and 2 t of Health If Item 27 i		20a. Method of Disposition 1 □ Burial 2 ☑Cremation 3			Place of Dispo				Date 1 /10 /06			13.1	Town, State	3
altim	permit. Pages 1 Department of H Important: If Ite any injury or ot		* 4 □ Donation 5 □ Other (Spec		1 -			_		1/19/06				, Maryla	
ä	Depa Impo any ii		102			1	237 E.	y-Po Pai	capsco	Funera Ave., B	alto	me,	Md. A.	21225-18 Approximat	
	Physician		23a. Part1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	_aCon	gest	IVE F	tear	+	Failu	I P	ry arrest,			Interval Bet Onset and I	ween
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Division of Vital Records, P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		h 2 ∏Feta nt at time of d	Ideath 3	Ectopic pre Other (spe					230	d. Date of de Month		∕ o ar
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ion of	nding Phys th. :: After this s funeral di	H-1	27. Manner of Death Natural 5 Pending Accident investigati	28a. Date of (Month,		28b. Time o Injury		c. Injury Work	at	28d. Descr				ecity)	
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	Hospite 24 hours Funera stely fille	Medicai (29a. Certifier 1 Certifying F (Check only one)	Physician: To the bearings: On the bas	is of examina	wledge, deat tion and/or in	h occurred a vestigation,	it the tim	ne, date and ploinion, death o	ace, and due to ccurred at the til	the caus ne, date	e(s) ar and pl	id manner a ace, and du	s stated. e to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	A	17				number		29d.	Date s	signed (Mon	th, Day, Year)	
	3		30. Name and address of person wh	completed cause	ol death (Item	п 23а) (Туре,		ソン	866			11	1200	00	
	Sta	te	31. Date filed (Month, Day, Year)	15h 4	(060 (gistrar's Signa	NI/KAI	15AVE	nu	54	ltimore	2, 1.	10	21	279	
	Registr	-	JAN 1 9 2006	Barrens,	18	Societa	8								

Robert J. Casey 06 - 0395Unpend item#1 State of Maryland / Department of Health and Mental Hygiene AKG For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 15, **Physician** 2006 6:15 P Christopher Robert Casey /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore County 7916 Gough Street Dundalk If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Min 1XM 2□ F Months Days Hours Yrs. 218-84-3022 1971 Director Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f show d other than "natural", or iteme 23s or 28s-f show event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Directo Maryland **Baltimore** Dunda1k 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21224 7916 Gough Street death by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after Never Married 2 ☐ Married i ∐Yes 2 XNo fYes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify Specify. White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: if tiem 27 is marked other than "n eny injury or other traumatic event, the Macal Elementary/Secondary (0-12) College (1-4or 5+) Food Service Cook 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Robert Poling Dolores Casey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1327 Gilbreath Road Sadler, Dolores Skeen/Mother TX 76264 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ② Cremation 3 ☐ Removal from State Metro Crematory, Inc. 1/19/06 Baltimore, MD 4 □ Donation 5 □ Other (Specify) $^{22.\,Name\ and\ Address\ of\ Facility}$ Cremation Society of MD, Inc. 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Cremation So

Fdward A Gregorchik

239 Frederick Road Saltingre

23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. <u> 299 Frederick Road Baltimore, MD 21228</u> Immediate Cause (Final disease or condition resulting in death) Methadone Intoxication Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospitei or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Year ō in the past 12 months? Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Should 24b. Were autopsy findings available prior to completion of cause of death?

1.2 Yes 2□ No 24a. Was an s certificete hes t lirector, page 2 s 2 No Yes 2 No Yes Division of Vital 25. Was case referred to medical examiner?
120 ves 2 □ No 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Director: After this of in by the funeral director 28a. Date of Injury TRI (Month, Day Year) 28b. Time of Injury unk 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 XNo 1/15/2006 death. 2 Accident 6X Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number. City or Town, State) 7916 Gough St. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide after Dundalk, MD 1 24 hours af 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only 2 XMedical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E. January 16, 2006 and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

ch loc

2006

JAN19

31. Date filed (Month, Day, Year)

32. Registrar's Signature

111 Penn Street, Baltimore, Maryland

		State of Marylan 1 - For State of Marylan		artment of F			ene g. No. 2006	00958
Physici	an	Decedent's Name (First, Middle, Last)				2. Date of Death	Bay Yea	3. Time of Death
/Medic	al	JOsephine Cochran 4a. Facility Name (If not institution, give street and number)		4h Cihi Toum o	r Location of Death	01	4c. County of De	
Examin		Holy Cross HOspital		Silver			Montgon	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. B	irthplace (State or Foreign Country)
Director		252-09-3035 1 1 M 2 M 94 Usual Residence of Decedent	Yrs.			02 25	ll Sou	ith Carolina
ow III		10a. State 10b. County 10c. Cit	ty, Town or Lo				· · · · · · · · · · · · · · · · · · ·	10d. Inside City Limits
a-f eh	tor	DC W	ashingt	ton				1 AYes 2 □ No
or 28	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What (Country?
eath w	erai	14 Underwood Street N.W.	S 12 1	20012	lispanic Origin? (Sp	acify Ves or No-	USA	nerican Indian,
fter de	by Funerai	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No	li li	f Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)	Black, Wh	
ours a		3 ☑ Widowed 4 □ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No	Specify:		Specify: E	Black
netu ration	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of work	ing 1	6b. Kind of Busines	s/Industry
i withir	ошо	Elementary/Secondary (0-12) College (1-4or 5+) 2 VIS.		Beauticia	•		Self Empl	oved
other	BeC	17. Father's Name (First, Middle, Last)	·	reauricia.	18. Mother's Name	e (First, Middle, N	faiden Sumame)	oyeu
Idel yidelity Z IZ ID-0000 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "naturel", or iteme 23s or 28s-f ehow eumatic event, the Markes Exertination mail to notified at	To	Yancey Pitts				e Coins		
Vial 32 sh h and 7 is m treum		19a. Informant's Name/Relationship (Type, Print) Yancey Pitts, Jr./Brother			and Number or Run St. N.W.		City or Town, State	, Zip Code)
Healt Healt tem 2		20a Method of Disposition 20b. F	Place of Dispo	sition (Name of	1		20c. Location - City	or Town, State
Pages ent of ry or o		1 Description 2 Cremation 3 Hemoval from State	· .	natory`or other plac Cemetery	1-14	-06	Atlanta,	GA.
parifiliore, individual Z 12.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Importent: if item 27 is marked other than "naturel; or iteme 23a or 28a-f show appringury or other treumatic event, the Madical Examination missible and once.		21. Signature of Funeral Service Licensee	22	2. Name and Addre	ss of Facility Mar	shall's	Funeral H	ome
0 83558		of Markall		4217 9t	h. St. N.	W. Washi	ngton, D.	C. 20011
		23a. Part / Enter the disease, or complications that caused the deat shock or heart failure. List only one cause on each line.	h. Do not ente	er the mode of dyir	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
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th cert tendin r use	an/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Feta	ancy aldeath 3□	Ectopic pregnancy	,		23d. Date of c	· ·
the att	/sici	in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown 9 □ Unknown	leath 5□	Other (specify)			Month	Day Year
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quires t quires t n signe	d b	Dementia				1 □ Ye	s 2□No 3□	Probably 4. Unknown
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nding ath. r: Afte e fune	atior	1 ⊠Natural 5 □ Pending (Month, Ďay Year) 2 □ Accident investigation	Injury		rk? Yes 2 □No			
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Hos 24 ho Fun etely f	edicai	29a. Certifier 1 X Certifying Physician: To the best of my kni (Check ority 2 Medical Examiner: On the basis of examiner one) and manner stated.	ation and/or in	n occurred at the till vestigation, in my o	me, date and place, opinion, death occur	and due to the ca red at the time, da	use(s) and manner ite and place, and d	as stated. ue to the cause(s)
To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	₩ W	29b. Signature and title of certifier		29c. Licens	se number	29	9d. Date signed (Mo	nth, Day, Year)
		Tadmalatha m.D		Do	060038		1/7/	0.5
3		30. Name and address of person who completed cause of death (Itel		Print)			7	
	ate	Dr. Padmalatha, MD. 1500 Fore 31. Date filed (Month, Day, Year) JAN 1 9 2006	st Gler	n Road, S	Silver Spi	ing, MD.	20910	
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			Registrar	Α.		Certi	ilcate of	Dealli	2. Date of D	Reg. No	:	3. Time of Death
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	/Medic	al	4a, Facility Name (If not institution, give					or Location of Dea	Januari		ことの (g . County of Deat	
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	-		5. Social Security Number 6. S		In yrs. last birt		If Under 1 Year	OWN U	rs. 8. Date of Bi	irth	9. Birti	hplace (State or Foreign
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Saltimor	Department Importent: If any injury or once.		21. Signature of Fune al Service Licer	$\therefore A \cap \mathbb{R}^n$	0-1		Name and Addr		Gonce Fu			
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/6U,	the attending physician and hed for use as the burial-transit	calE		d								
	phy.			· ·								
Records, P.O. Box 68	nding use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	pregnancy	. Or					23d. Date of dei	ivery
ă	a atte	Cla	in the past 12 months?	1□Live birth 2 4□Pregnant at ti			ctopic pregnand Other (specify) _	cy			Month	Day Year
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J 1	igned be det	by P	Part II. Other significant conditions	contributing to death but	not resulting is	n the und	lerlying cause g	iven in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
ğ	been sig								_ VZ	Yes 2	□No 3□Pr	obably 4 Unknown
ecords,	s bec	Completed							24a. Wa	s an opsy	24b. Were at	utopsy findings available completion of cause of
ž į	page 2 s	E							per	formed?	death?	2 No
		O	25. Was case referred to medical					26. Place of D	eath (Check only			
> 3	this cert	To B	examiner? 1 \(\text{Yes} \) 2 \(\text{No} \)	Hospital: 1 Inpatien	2 ER/0	utpatient	3□ DOA	ther: 4 \(\text{Nursing}	Home 5□Res	sidence	6 ☐ Other (Spe	cify)
0 8	h. After th funeral	i:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day	Yeer) 28b.	Time of Injury	28c. Inju		28d. Describe			
Division of	leath. Ior: Af the fu	atlc	2 Accident investigation				M 1	Yes 2 □ No				
	er de recto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		y - At home, fa (Specify)	arm, stree	et, factory, office)		(Street ar own, State		ural Route Number,
	rs after or rel Dir											
9	To the nospine or Attending Frigeroam. To the Funerel Director: After this certific completely filled in by the funeral director.	edical	(Check only 2 Medical Exe	nysician: To the best of miner: On the basis of e	examination ar							
	hin 2 the I	Med	one) 29b. Signature and title of certifier	and manner state	ed.		29c Licer	nse number		29d Da	ate signed (Mont	h. Day, Year)
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	11		7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	LE WOULT								
	7		30. Name and address of person who				rint) Wory	Silver	Spring	MA	20900	4
		ote	Zeleke Desse 1 31. Date filed (Month, Day, Year)	32 Registrar		1111	4		-1-10/01		. , -	/
line.	Donica	ate	JAN 1 9 2	nns Asses	1 1/2	10000	30 /60					

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Dey Month Year **Physician** ADELE CATLETT 4b. City, Town, or Location of Death 0625 2006 10 /Medical 4e Fecility Name (If not institution, give street end number) 4c. County of Deeth Examiner MERLY MEDICAL CENTER BALTINDRE CITY H Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Feb. 1, 19 If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Months Days 1 □ M 2 🗙 F 79 Yrs. 219 14 0549 Director 1926 Maryland Usuel Residence of Decedent filed within 72 hours after deeth with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or frems 23e or 28s-f ehow traumatic event, the Medical Examinar must be notified at Maryland 1 ☐ Yes 2 🖾 No Director Anne Arundel Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 8 West 2nd Avenue 21225 U.S. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 📆 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: þ Specify: White 3 Widowed 4 X Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) 6th College (1-4or 5+) Assembler Westinghouse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be Peges 1 end 2 should be nent of Health and Mental it of Health and Menta If Item 27 is marked Julius LeDuce Carrie Vogel 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Sue Ellen Ramsey / Daughter 8 West 2nd Avenue Baltimore, Maryland 21225 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 5 1 XBuriel 2 ☐ Cremation 3 ☐ Removel from State 1/13/06 Glen Burnie, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Glen Haven Mem. Park 21. Signature of Funeral Service Licansee Gonce Funeral Service, P.A. 22. Name and Address of Facility 4001 Ritchie Highway Baltimore, Maryland 21225 Geome 23a. Part. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as e consequence of): Examiner Acute Renal failure ettending physicien end for use es tha buriel-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Preumonia Physician/Medical Due to (or as e consequence of): ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown icata has been signe r, paga 2 should be d ģ Completed 24b. Were eutopsy findings available prior to 24a. Was an autopsy performed' completion of cause of death? 1 🗆 Yes 1 ☐ Yes 2 ☐ No this certificata or Attending Physician: tha funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 2 1 Tes Inpatient 2 ER/Outpatient 3□ DOA To the Hospital or Attending Pt within 24 hours efter daath.
To the Funeral Director: After th completaly filled in by the funeral Certification: 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 2 Accident 5 Pending investigation 1 Tyes 2 No 6 Could not be determined 3 Suicide Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted. 29a. Certifier Medicai 29c. License number 29b. Signature end tel of certifier 29d. Date signed (Month, Dev. Year)

MU41764356-15262

Josh (Item 230) (Type, Print)
30) ST PAUL PLACE MERCY MEDICAL CENTER BALTINON MO
21202

State Registrar

M.D.

PAUL GUSTAV

31. Dete filed (Month, Day, Year)

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

KLUETZ

32. Registrer's Signeture

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			partment of Health and M	lental Hygie	ene	
			ertificate of Death	Reg	No. 0 0 6	00961
3	ų.	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Yeer	3. Time of Death
Physicia /Medic		BETTLE Lee.	CARTER	JANUARY	15 7006	08:10 PM
Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	- 11	4c. County of Dea	th
		THE JOHNS HOPKING HOSPITA	R BALLIMORE	City	N	A
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	ear) 9. Bir	thplace (State or Foreign ountry)
Director		219-26-8918		May 9, 19	39	CM
and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
ith the Marylar or 28a-f show	ō	110 000				1 Nes 2 No
28a-	Director	NV N/A 15aUH	10f. Zip Code	100	. Citizen of What C	
23£ or		822 N Calayon Strant	21205	109	115	Ja .
filed within 72 hours after death with the Maryland Hygiene. Hygiene, then "natural", or items 23s. or 28s-f show ont, the Medical Evantrer must be notified at	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. 13		ecify Yes or No-	14. Race - Am	encan Indian
after dea or Items	Fun	1 ☑ Never Married 2 Married 1 Yes 2 ☑ No	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, Whi	te, etc.
ast, o	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: 3	lack
72 hours naturat,	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Gi	cedent's Usual Occupation we kind of work done during most of work	16	b. Kind of Business	/industry
an "	pje	Elementary/Secondary (0-12) College (1-4or 5+)	. DO NOT use retired)	ing		0
il Hygiene, other than	Con	124	Secretary		State	OF Maryland
d oth	Be (17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Ma	iden Sumame)	/
S should be filed with and Mental Hygiene, is marked other than aumatic event, the h	2	John P. Carter	Caleop	atra L	vacldel	
		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	iling Address (Street and Number or Fur		ity or Town, State,	Zip Code)
and ealth m 27			5 Hunter Creek k		onk, Pr	17402
Pages 1 nent of H int: If ite iry or ott		cemetery c	rematory or other place)		c. Location - City or	
Pag ment tant: jury o		'4 □ Donation 5 □ Other (Specify) Many I cm	I Nottonal Com Jamien	y 20,200G	Laurel,	MD
permit. Pages 1 and Department of Health Important: If item 27 any injury or other tronce.		21. Signature of Funeral Service License	I Northmal Com Jennien 22 Name and Address of Facility Havi P. CLOSE FL 5126 Belown Rock	nexal S	erulce, ,	P.A.
		, A Gu	5126 Belown Row	O, Baltin	none MB	21206-5105
		23a. Part1. Efter the disease, or complications that caused the death. Do not eshock, or heart failure. List only one cause on each line.	inter the mode of dying, such as cardiac	or respiratory arrest		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition regulation is death)				Onset and Death
/Medical Examiner		resulting in death) Due to (or as a consequence of):				West
	_		JAL DISEASE			5 YEARS
sit s	ine	cause. Enter Underlying				
and I-tran	Examiner	cause (ulsease or injury that initiated events resulting in death) Last C. HEPATITS Due to (or as a consequence of):				10 YEARS
						10 YEARS
	dicai	d CIRRHOSIS				TO TEAKS
death cartific attending p	03 1	IF FEMALE: 23c. If yes, outcome of pregnancy				
atten for u	Physician/M	in the past 12 months?	B Ectopic pregnancy Other (specify)		23d. Date of de Month	livery Day Year
the d	ysic	1 Yes 2 No 9 Unknown	Other (specify)			
res that the de signed by the a		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to	o the cause of death?
uires tha signad id be dei	d by		•	1 ☐ Yes	2 X No 3 □ P	robably 4 🗀 Unknown
w requir been si should	ete			240 1450 00		Annual Control
2 a a (Completed			24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
or Attending Physician: The aford and death. Director: After this certificate in in by the funeral director, page	-	05.10		1 ☐ Yes 2 X		2 🔼 No
Physician: rthis certificaral director, I	o Be	25. Was case referred to medical examiner? Hospital:		n (Check only one)		
ding Phys	\vdash	1 ☐ Yes 2 ☐ No 1 ☐ Sinpatient 2 ☐ ER/Outpate 27. Manner of Death 28a. Date of Injury 28b. Time		me 5 Resident 28d. Describe how		cify)
After fune	ation:	1 Natural 5 Pending (Month, Day Year) Injury		20d. Describe now	injury occurred	
deat deat ctor: y the	fica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm		28f. Location (Stree	at and Number or R	ural Route Number
after Dire	Certific	4 Homicide Homicide building, etc. (Specify)	stroot, tastory, office	City or Town, S		arar routo reamber,
spita tours neral	<u>a</u>	29a. Certifier 1. Certifying Physicien: To the best of my knowledge, de	ath occurred at the time, date and place.	and due to the caus	se(s) and manner a	s stated
To the Hospital or Attending within 24 hours after death of 10 to	edica	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occur	ed at the time, date	and place, and due	e to the cause(s)
To th	Me	29b. Signature and title of certifier	29c. License number	29d	Date signed (Mon	th, Day, Year)
		Who Kollians M.D.	RES - OOE) T.		5 7200
		30. Name and address of person who completed cause of death (Item 23a) (Typ		Up	enuary 1	5,2006
		4 14	STREET , BALTIMORE	MD 217	187	
Sta	te	31. Date filed (Month, Day, Year) 33. Registrar's Signature	,	11-11		
Registra	ar	JAN 1 9 2006	rette 1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** DASCH ERDY TANUARY 2:15 PM 16 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS BAYVIEW MEDICALCENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 187M 2□ F Director 213-26-2442 May 31, 1930 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City. Town or Location 10a State 10d. Inside City Limits r than "natural", or Itams 23s or 28a-f show the Medical Exempter must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7293 Gough Street 21224 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☑ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2/2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be flied v
Department of Health and Mental Hygie
Important: if Itam 27 is marked other ti
any injury or other traumatic avant, Iba
once. Millwright Steel Manufacturing 11 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Dasch Margaret Heymann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7293 Gough Street Rachele Dasch (Wife) Baltimore, Maryland 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1.☐.Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ ther (Specify) Helly Hill Mem. Gdns 1/20/2006 Middle River, Md. 21. Signature of Plyndral Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the wath, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) INTRACEREBRAL HEMORRHAGE **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Examiner The law requires that the death certificate be executed physicien and the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending pt for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) been signed by the should be detached ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CHRONIC OBSTRUCTIVE PULMONARY DISEASE 1 Yes 2 No 3 Probably 4 Unknown ESOPHAGEAL CANCER 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificete has t irector, pege 2 s autopsy 1 🗆 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: Certification: To Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Director: After that in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide within 24 hours af To the Funeral D completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) RES-000 JANUARY 16, 2006 ishiena (sandh, MD

10+19

State Registrar

DHMH 17 Rev 1/2001

NISHIENA 31. Date filed (Month, Day, Year)



30. Name and address of person who is impleted cause of death (Item 23a) (Type, Print)

4940 EASTERN AVENUE, BALTIMORE MD 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1,55D M Mar a NUARI /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner If Under 24 Hrs. If Under 1 Year 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 96 Yrs. 1 ☐ M 2 ☐ F 15-22-8703 Director Usuel Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 'natural', or items 23s or 28s-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or tiems 23a or 28a-f show any injury or other traumatic event, the Medical Examiner anal be notified along. 1 Pres 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21209 USA Funerai Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Health care Keaiskrea NURSE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edward Hose 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SONA 2224 presenta tive 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State * 4 □Donation 5 □ Other (Specify) 04 timore remators 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FUNERA radley 222 WI 1455 34 110u Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC TO BONES PRIMARY CANCTER UNKNOW /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner signed by the attending physician and does detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Medical Certification; To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No this certificate has autopsy 2 No 1 Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 2 No 1 🗌 Yes 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mannet of Death 28b. Time of 28d. Describe how injury occurred after death. Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 016619 summany Mo 16, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9940 FRANKLIN BALTIMORE, M.D. 21236 SQUATE DRIVE C.VERGARA-SOARES 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 9 2006 Registrar

			For State Registrer	State of Marylan	d / Depa	artme	ent of H			ntal Hy		006	0096	a de la companya de l
*	Physici /Medio Examin	al	Decedent's Name (First, Middle, La RUTH Aa. Facility Name (If not institution, giv. 1 POMONA EAST #	V. e street and number) 412		4b. Ci	IKES	r Location of Dea	JΑ	Date of De Month NUARY	14,	2006 County of De	4:15 P ath ORE	М
1	Funeral Director	2	5. Social Security Number 6. S 215-32-3250 Usual Residence of Decedent	Sex 7. Age (In yrs. 1 Age (Sex 2 F 85)	iast birthday) Yrs.	Month	der 1 Year is Days	If Under 24 Hrs Hours Min		Date of Bir (Month, Da G. 3,	ay, Year)		irthplace (State or Fi Country) MD	oreign
	the Maryland 28a-f ehow	Director	MD BALTI 10a. State 10b. County MD BALTI		y, Town or Lo	SVIL	LE Zip Code				10g. Cit	tizen of What (10d. Inside City L 1 ☐ Yes 2	
036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23s or 28s-1 show other traumatic event, it's Mudical Examinations the nutitied at	Completed by Funeral Di	1 POMONA EAST # 11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	412 12. Was Decedent Ever in U. Amed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:				L208 dispanic Origin? (San, Mexican, Puel Specify:	Specify to Ric	/ Yes or No an, etc.)	0-	USA 14. Race - An Black, Wr Specify: W	nerican Indian, lite, etc. HITE	
21215-0036	d within 72 ho giene. ir then "natur ir e Mudical	ompleted	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	16a. Dece (Give life.	kind of DO NOT	work done of use retired	during most of wo	orking		16b. K	ind of Busines	•	
Maryland	should be filed and Mental Hygis marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last, HARRY	В.	DUKE			18. Mother's Na		ALVE	RTA		WOODS	
	and 2 sh ealth and n 27 ls m		19a. Informant's Name/Relationship (JUDY ROSENBERG /	FRIEND	1 P0I	ANON	EAST	#508 -	PI	KESVII	LLE,	MD 212	208	
Baltimore,	Page nent o ant: If ary or		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specil	Removal from State	Place of Dispo emetery, crea H EL M	matory o	or other plac	^{∞)} PARK 01/1	Date 17/2			ocation - City o		
Balt	permit. Depertr Imports eny Inju		21. Signature of Euroral Service Top	nsee	22	2. Name	and Addre	ss of Facility S	OL 1	LEVIN	SON	& BROS.		3
	Physician /Medical Examiner		shock, or hear fature. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the death one cause on each line. a	CORO	ter the m	ode of dyin		ic or re				Approximate Interval Betwee Onset and Dea 5 YEAF	en ath
8760,	ate be executed hysicien and the burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conseq c. Due to (or as a conseq d										
Division of Vital Records, P.O. Box 68	Attending Physician: The law requires that the death certificate be executed refath. cleath. ector: After this certificate hes been signed by the attending physicien and by the tuneral director, page 2 should be detached for use as the burial-transit.	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3		pregnancy (specify)	<u>'</u>				23d. Date of d Month	elive <i>r</i> y Day Yea	ır
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Divis	는 다음 다음	Certification;	3 Suicide 6 Could not be determined	building, etc. (Specif	y) 					City or To	wn, State	a)	Rural Route Number	
213	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier 1 Certifying Pl (Check only 2 Medical Exel	hysicien: To the best of my kno miner: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurr vestigati	ed at the tir ion, in my o	me, date and place pinion, death occ	e, and urred	due to the at the time,	cause(s date and) and manner d place, and d	as stated. ue to the cause(s)	
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,			Mulle TY	cay)	0.230\ /T		D1809	5				01/18/2	006	
	1		30. Name and address of person who MICHAEL T. RUDI	KOFF 1838 GRI	EENE T		ROAD	- PIKESV	/ILL	.E, MI	212	208		
	Sta Regist		31. Date filed (Month, Day, Year)	32. Big trar's Signa	ature	- A	B 18							

VOID

CERTIFICATE

2006-00965

SEE

CERTIFICATE #

2005-43867

	W. 171. 111.		1 - For State Registrar	State of Maryl	•	artment of rtificate of			Reg. No.	<u> </u>	10066
	Physici	an	Decedent's Name (First, Middle, Last TIMOTING TIM	")	ET EX	7		2. Date of De		2 ×300	1 Us. Ilmb-bi Death 06 12:26A M
	/Medio		TIMOTHY 4a. Facility Name (If not institution, give	street and number)	ELEY	1	, or Location of	-		unty of Dear	
, i			DOCTORS COMMUNIT				LANHAM		F	RINCE	E GEORGES
	Funeral Director		5. Social Security Number 6. Se Xi	x 7. Age (In) XM 2□F	vrs. last birthday) 59 Yrs.	Months Day		Min. (Month, Da	th a <i>y, Year)</i> 9, 1946	Co	thplace (State or Foreign ountry) RGINIA
	÷		Usual Residence of Decedent					DDI • I	7, 1740) VII	
	Aarylan f show	ō	MD PRINCE GE		. City, Town or Lo	ocation					10d. Inside City Limits ▼ Yes 2 □ No
	death with the Maryland ms 23a or 28a-f show tritual be notified at	Director	10e. Street and Number	OKGED L	ANDOVER	10f. Zip Code)		10g. Citizen	of What Co	
	23a o		7618 SWAIN TERRAC	E			20785		UNIT	ED STA	ATES
320	thin 72 hours after death with the Maryla e. an "natural", or Items 23a or 28a-f shov Madical Examinat the Lotified at	by Funeral	11. Marital Status 1 Never Married XX Married 3 Widowed 4 Divorced	12. Was Decedent Ever i Armed Forces? 1 ☐ Yes ※ ※ ※ No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cu 1 ☐ Yes XX N		n? (Specify Yes or No Puerto Rican, etc.)		Race - Ame Black, Whit ecity: $\mathrm{BL}A$	
212-0036	72 ho	eted	15. Decedent's Edu (Specify only highest grad	ucation le completed)	(Give	dent's Usual Occ	e during most o	of working	16b. Kind o	of Business	/Industry
7	within 72 ene. than "nai	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	<i>DO NOT u</i> se <i>retii</i> INSTALLE	red)	•	THOUN	ኮ ጥድረነ	HNOLOGIES
7	Hygi Hygi ther ant,	Be Co	17. Father's Name (First, Middle, Last)	2 YRS.		INSTALLE	1	s Name (First, Middle	1		HNOLOGIES
/land		To B	UNKNOWN				ROSE	CTTA ELEY			
Mar	s 1 and 2 should f Health and Mer Item 27 Is marke other traumatic		19a. Informant's Name/Relationship (7)	·				or Rural Route Numb			Zip Code)
	tem 27		SHIRLEY M. ELEY / 20a. Method of Disposition	20	b. Place of Dispo	1 LAKEVI psition (Name of		DAMAN,	PX 774.		Town, State
Ê	Page lent o nt: If ry or		XX Burial 2 Cremation 3 If 4 Donation 5 Other (Specify)		INCOLN (matory`or other p. CEMETERY	· I	A JAN 2006	PORT	SMOUT	H, VA
Baltimore	permit. Departm Imports any inju		21. Signature of Funeral Service Licens	will	2:	MARSHAL 4308 SU		ERAL HOME ROAD SUI	OF MAR		
	Physician /Medical Examiner physician and physician and physician the pricial fluorest physician and	dical Examiner	23a. Parth Enter the disease, or comp shots or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ne cause opteach line.	sequence of):	1 C	ying, such as ca	ardiac or respiratory a	rrest,		Approximate Interval Between Onset and Death
O. BOX 6	death certifi e ettending ed for use as	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown	etal death 3	Ectopic pregnan Other (specify)	осу		23d.	Date of del Month	ivery Day Year
S,	requires that the een signed by th hould be detache	by P	Part II. Other significant conditions co	ntributing to death but not	resulting in the u	inderlying cause o	given in Part I.				the cause of death?
cora	v requi	eted	TTY por Jensi	07-					Yes 2 N		
итан же	The larate has	e Completed	25. Was case referred to medical				00 0	1 Yes	ormed? 20 No	death?	utopsy findings available completion of cause of
	S W T	To B	examiner?	Hospital: 1 ☐ Inpatient	2 ER/Outpatier	nt 3 DOA	thor	of Death (Check only only only only only only only only		Other (Spe	cifv)
lon of	ding After fune		27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yea		f 28c. Inj		28d. Describe			,
UIVISION	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Abuilding, etc. (Sp	At home, farm, streecity)	reet, factory, office	е	28f. Location (City or To		imber or Au	ural Route Number,
	To the Hospi within 24 hour To the Funer completely fill	edical	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my iner: On the basis of exan and manner stated.	knowledge, deat nination and/or in	h occurred at the vestigation, in my	time, date and opinion, death	place, and due to the occurred at the time,	cause(s) and date and pla	manner as	s stated. to the cause(s)
,	To T To II	X	29b. Signature and title of certifier	Kur 1	10	29c. Lice	se number	78	Janua	ined (Mont	n. Day, Year)
	り		30. Name and address of person who co	ompleted cause of death (M-D- 575 M)	Item 23a) (Type,	Print) SOITE	E 351	AUXEL, N	13 20	207	,
200	Sta	ite	31. Date filed (Month: Day, Year)	32; Registrar's S		946e					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Req. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month FORD LAURA BETTY 24c. County of Death 100 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Nedical Cetiter Security Number 6. Sex len Burnie nder 1 Year | If Under 24 Hi Hrunde ! Birthplace (State or Foreign Country) 5. Social Security Number 235-52-8794 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Months Hours 1□M 21 F June 07,1936 West Virginia Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Baltimore Essex Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 1000 Franklin Avenue Apt. 814 21221 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Waitress Honey Bee Diner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Norman C. Lovill Katherine Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 459 Community Road, Severna Park, Maryland 21146 Linda F. Johnson (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State Meadowridge Mem Park 01-20-06 Elkridge, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Fun-val Service Lic McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 23a Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a conseq Due to (or as a consequence of). Due to (or as a consecutive of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Pres 2 No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown

Physician /Medical **Examiner**

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the attending physician

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the Hospitel or Attending hin 24 hours after death. the Funerel Director: After

within 24 hours a To the Funerel C

requires that the death certificate be

Box 68760.

Division of Vital Records, P.O.

Physician

/Medical

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Director

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy

2 1 No

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Diapatient 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Yes 2 No

3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide

and manner stated.

281. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

31. Date filed (Month, Day,

1 Yes 2 No

27. Manner of Death

1 CHatural

2 Accident

1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number

1 ☐ Yes

29b. Signature and title of certifier

5 Pending investigation

6 Could not be

DO014147

2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William

widson

9 2006

Year)

State Registrar

305 Hospital 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene

				Otato of Ivia	i yiaiia		ficate of	Death		2,000	00)968
	S 1		1. Decedent's Name (First, Middle, Las	t)					2. Date of Dea Month	th Day	Year	3. Time of Death
*	Physici /Medi		ELSIE MAE FRIERS	ON					JANUARY			4:28P
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	,		LARKIN CHASE NUR		the constant	4 6 2 46 45	f Under 1 Year	BOWIE	Doto of Birth		CE GEO	
	Funeral Director		5. Social Security Number 6. Security Number 114 22 4267 Usual Residence of Decedent	x /. Age □ M X2X0 F	(In yrs. last	N	Months Days		8. Date of Birth (Month, Day APR. 06	Year)		ce (State or Foreign) GINIA
	land	ŀ	10a. State 10b. County		10c. City, T	own or Locat	ion				10d	I. Inside City Limits
	Mary Hear	ģ	MD PRINCE G	EORGES	HPPF	R MARI	BORO				i	XX Yes 2 □ No
	h the	<u>e</u>	10e. Street and Number		0111		10f. Zip Code		1	0g. Citizen of V	Vhat Country	/?
	th wit	Funeral Director	13507 MISSOULA C	OURT				20774		UNITED	STAT	ES
	ema er m	ner	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U,S.	13. Wa	s Decedent of l	Hispanic Origin? (S pan, Mexican, Puer	pecify Yes or No-		a - American	
Maryland 21215-0020	n 72 hours after death with the Maryland "natural", or itema 23a or 28a-1 show sideal Examiner must be notified at	<u>م</u>	1 ☐ Never Married XX Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes ZXNo If Yes, Give Year or Dates:			Yes XXNo		, , , , , , , , , , , , , , , , , , , ,		BLACI	
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and	ntel h	Be B								vialuen Sullian	10)	
2	d 2 should be the fine and Mentel the standard of traumatic events	오	THOMAS SCOTT 19a. Informant's Name/Relationship (T.	vne Print)		19b. Mailing	Address (Stree	HATTIE t and Number or Ri	MASON	. City or Town.	State. Zip Ci	ode)
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ē,	ies 1 and 2 of Health e f Item 27 is r other trai		20a. Method of Disposition	,	20b Place	e of Dispositi				20c. Location -		
E O	Pages nent of I nrt: If Ite		1 ☐ Burial XXX Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify)			-	AN CREI		1/18/06	ΔΙΕΥΔ	NDRIA	VΛ
Baltimore,	permit. Pages Depertment of Important: If It any Injury or o		21. Signature of Funeral Service Licens		111211	22. N	ame and Addre					
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Division	l or Attendi efter death Director: A d in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	y - At home (Specify)	, farm, street	, factory, office		28f. Location (Si City or Town	reet and Numb n, State)	er or Rural R	loute Number,
	To the Hospital or A within 24 hours efter To the Funeral Director Completely filled in b		29a. Certifier \ \ XX Certifying Phy	sician: To the best of	my knowle	dge, death oc	curred at the ti	me, date and place	, and due to the ca	ause(s) and ma	nner as state	ed.
	the Hos hin 24 h the Fur npletely	edicai	(Check only 2 Medical Exami	iner: On the basis of e and manner state	xamination	and/or inves	tigation, in my	opinion, death occu	rred at the time, d	ate and place,	and due to th	e cause(s)
	To th To th comp	×	29b. Signature and title of certifler				29c. Licen	se number	2	9d. Date signe	(Month, Da	y, Year)
							D5	7028		JANUARY	18, 2	006
	13	-	30. Name and address of person who c	ompleted cause of dea	ath (Item 23	Be) (Type, Pri		7.5				
	\		ADITYA CHOPRA, M				Y_AVE.	#231 A	NNAPOLIS	MD 21	401	
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			1 - For State Registrar	State of Marylan	-	artment of I		1	909 06	00969
	0.		1. Decedent's Name (First, Middle, La.	st)				2. Date of Death		3. Time of Death
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je .	Examir		4a. Facility Name (If not institution, giv			4b. City, Town, o	or Location of Deat		4c. County of Dea	
			2299 West	Svi-10 hoor		11/	aldorF		Che	11/25
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Birth (Month, Day,		thplace (State or Foreign
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	D .		Usual Residence of Decedent							
	nylar how		10a. State 10b. County	10c. Cit	y, Town or Lo		-			10d. Inside City Limits
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	or 26	Jire	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	
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36	or II	J. F.	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 ☑ No If Yes, Give		1 Yes 2 No				black
21215-0036	within 72 hours after death with the Maryland ane. then 'naturel', or Items 23a or 28e-f show 'a Mudical Exer'ill at trastice notified at	d by	3 Nawed 4 □ Divorced	Year or Dates:						
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کّ	Pages nent of I int: If its		1 ☑Burial 2 ☐ Cremation 3 ☐	Removal from State	emetery, cre	matory`or other pla				
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			23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each line.	ni. Do not en	ter the mode of dyl	ng, such as cardia	or respiratory arres	st,	Approximate Interval Between Onset and Death
	Priysician		Immediate Cause (Final disease or condition resulting in death)	a PU~	manun	1 Embi	sins			weeks
	/Medical Examiner		1630King in deality	Due to (or as a conseq	uence of):	7				10
		<u>.</u>	Sequentially list conditions,	b. Due to (or as a conseq	10					KIL
	pe tisi	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury			120	D.c. (0		4.00
	and and Il-trar	xan	that initiated events resulting in death) Last	C. Due to (or as a conseq		aszulu	Disens	X.		1400 5
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	ical E		(
87	phys the	edic		d						
9 ×	death certifica attending ph d for use as th	/Me	IF FEMALE:	23c. If yes, outcome of pregna	incv				2015	
Вох	atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	l death 3	Ectopic pregnanc Other (specify)	у		23d. Date of de Month	Day Year
o.	that the de ed by the detached	Physician/M	1 ☐ Yes 2 12 No 9 ☐ Unknown	9□ Unknown	Balli St	_ Other (specify) _				
4	res that the igned by be detact		Part II. Dther significant conditions of	ontributing to death but not res	ulting in the u	inderlying cause giv	ven in Part I.	23e. Did toba	icco use contribute to	the cause of death?
Records,	sign d be	d by	Dementic	\				1 ☐ Yes	2 □ No 3 □ P	robably 4 Unknown
Ö	w requir been s should	Completed						240 1460 00	24h Mara a	utong, findings aveilable
3e	has has	mp						24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
	ician: The l certificate ha rector, page								ZNo 1□Yes	2 No
Vital	Attending Physician: r death. sctor: After this certification the funeral director.	Be	25. Was case referred to medical examiner?	Hospital:		_ Ott		ath (Check only one)		
of	Phys ral di	. To	1 Yes 2 No 27. Man er of Death	1 Inpatient 2	ER/Outpaties 28b. Time of	nt 3 DOA	4 Nursing H	lome 5 Residen 28d. Describe how	ce 6 Other (Spe	cify)
no	ding Ph h. After th funeral	tion	1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	Injury	Wo	rk?]Yes 2 ☐ No	200. Describe now	rinjury occurred	
Si	Attendii er death. rector: A by the fu	Ca	3 Suicide 6 Could not b		me farm et		1.00 2.010	28f Location (Stre	et and Number or R	ural Route Number
Division	after Direction by	Certification:	4 Homicide determined	building, etc. (Specif	y)	root, ractory, office		City or Town,		siai i i odio i i dilibor,
	Tc the Hospitel or Attenwihin 24 hours after deati To the Funerel Director:		29a. Certifier 1 Certifying Ph	ysician: To the best of my kno	wledge, deat	h occurred at the ti	me, date and place	and due to the car	ise(s) and manner as	stated
0	24 h	edicai	(Check only 2 Medical Exar	niner: On the basis of examina and manner stated.	tion and/or in	vestigation, in my	opinion, death occi	irred at the time, dat	e and place, and due	to the cause(s)
21	To the Hospite within 24 hours To the Funerell completely filled	₹ E	29b. Signature and title of certifier	1		29c. Licens	se number	290	d. Date signed (Mont	h, Day, Year)
	~ > F 0		D.J. 10.9	1)0110000	MI	, n.	04047	G	11,010	(
•			30. Name and address of person who	completed cause of death (from	23a) (Type		09091	1	.1 1010	9
			0. 1. 1	avison Jr	- NA E	3 170	70 040	Line Cont	than a s	MO
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture		, , , , ,	- CHIL		
**	Regist		JAN 1 9 2006	Mount A	Search.	A .				

			For State Registrar	State of Maryland	•	nt of Health and te of Death	Mental Hygier	11116 11	0970
1	Physicia /Medic	al	1. Decedent's Name (First, Middle, Las Edward Aa. Facility Name (If not institution, give	. Grancki	4h Cin	r, Town, or Location of Deat	2. Date of Death Month O \ — O	Day Year 7 - 200 6 4c. County of Death	3. Time of Death
**	Examin Funeral Director	er 	Good Sariai 5. Social Security Number 6. Si	itan Hospit	-al P	alfure er 1 Year If Under 24 Hrs	8. Date of Birth	NA	olace (State or Foreign ntry) WK
	e Maryland a-f show	ctor	Maryland 10b. County	A 10c. City,	Town or Location	ore		1	10d. Inside City Limits 1 (XYes 2 □ No
036	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show polical Extrating the notified at	by Funeral Director	10e. Street and Number HI3 WOOD 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	PCU AUC, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		ip Code 2 / 2 / 6 adent of Hispanic Origin? (Secrify Cuban, Mexican, Puer 2 / 10 / 10 / 10 / 10 / 10 / 10 / 10 /		14. Race - America Black, White,	can Indian,
ld 21215-0036	filed within 72 Hygiene. other then "na ent, ire Moulc	Be Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	life. DO NOT	ork done during most of wo use retired)	rking 16b. The first, Middle, Maid	Kind of Business/In	Firm
Maryland	d 2 should h and Men 7 Is marke traumatic	ToB	19a. Informant's Name/Relationship (Type, Print) Socia	19b. Mailing Addres	unk. ss (Street and Number or Ri	ural Route Number, Cit	y or Town, State, Zir	unk.
Baltimore,	ermit. Pages 1 and epartment of Healt nportent: If Item 2 ny injury or other nce.		20a. Method of Disposition 1 Burial 2 Ocremation 3 4 Donation 5 Other (Specify	Removal from State ()	ice of Disposition (Nametery, crematory or	ame of other place) matory 1/2	Date 20c. 3/2006 P	Location - City or To	own, State
Ball	permit. Pad Department Importent: eny injury once.		21. Signature of Funeral Service (licer	L. Buss	Josep 2222	h L. Russ W. North Ave	. Balto.	Home, P. F. Ma. 21216	Approximate
No.	Physician /Medical Examiner		short, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a conseque	ive the		urc		Interval Between Onset and Death
1,092	te be executed ysician and ie burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conseque	ence of):	si's			
P.O. Box 687	The law requires that the death certificate i ate has been signed by the attending physion page 2 should be detached for use as the i	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnand 1 Live birth 2 Fetal d 4 Pregnant at time of dea	death 3 ⊟Ectopic			23d. Date of deliver	ery Day Year
Records, P.	wrequires that i been signed by should be deta	Ď	Part II. Other significant conditions of	Perinheral V	Lacry lov	and the second s		co use contribute to the	he cause of death? bably 4 []Unknown
al Reco	ilcian: The law r certificate has be rector, page 2 sh	Completed	(OPD, Ac	ule renal fa	luve		24a. Was an autopsy performed 1 Yes 2 1	prior to co death?	opsy findings available impletion of cause of
ion of Vital	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner ath 1 Chitural 5 Pending 2 Accident investigation	(Month, Day Year)	R/Outpatient 3 C 28b. Time of Injury	Othor	ath Check only one) Home 5 Residence 28d. Describe how in		(ty)
Division	Itel or Atters after der al Directo	Certification;	3 Suicide 6 Could not b determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, facto	ory, office	28f. Location (Street City or Town, St.	t and Number or Rura late)	al Route Number,
	the Hosp in 24 hou the Fune pletely fil	Medicai	(Check only 2 Medical Exar	nysician: To the best of my knowl niner: On the basis of examination and manner stated.	on and/or investigation	on, in my opinion, death occ	urred at the time, date a	and place, and due to	o the cause(s)
	To To Com	2	29b. Signature and title of certifier	-, mD		9c. License number 0 6053		Date signed (Month,	
1			30. Name and address of person who	IND; 5601	Loch Ra	ven Blud.	Baltimor	e, mj	21239
	Sta Regist	ate rar	31. Dails filed (Month, Day, Yeal)	32 Registrar's Signatu	ire Asset				

		_	1 - State of Mar		artment of H		901	ne N.6 00	971
	Physici /Medic Examin	al	Decedent's Name (First, Middle, Last) Bernice Gaskins 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		Day Year 12 06 4c. County of Dear	3. Time of Death 4:50 A M
	Funeral Director		578-30-2941 1□M 2対F 82	(In yrs. last birthday) Yrs.	Laurel If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye		orges hplace (State or Foreign nuntry) hington, D.C
	he Maryland 8a-f show	Director	DC	Oc. City, Town or Lo Washingt	on				10d. Inside City Limits 1√ Yes 2 □ No
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. Ided ther than "natural", or Items 23a or 28a-f show event, the Medical Evarili withreast be inclified at	by Funerai	10e. Street and Number 1724 Independence Avenue S. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education Plated	er in U.S. 13.	10f. Zip Code 20003 Was Decedent of Hi If Yes, specify Cubar 1 Yes 2 No	Specify:	ecify Yes or No- Rican, etc.)	USA 14. Race - Ame Black, Whit Specify: B1 D. Kind of Business	encan Indian, e, etc. ack
1d 2121	filed within Hygiene. other than " ent, the Mes	Be Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) 6th. 17. Father's Name (First, Middle, Last)		kind of work done of DO NOT use retired, rses Aide		ng i (First, Middle, Mail	Hôspital den Sumame)	
Maryland	2 should and Mer is marke sumatic	ToB	Charles Cephas 19a. Informant's Name/Relationship (Type, Print) Carolyn B. Thornton/Daughte	1	ng Address (Street a		l Route Number, C		
Baltimore,	Pages 1 and 3 ment of Health sent: If item 27 jury or other tr.		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	20b. Place of Dispo cemetery, crer		g) C		Location - City or	Town, State
Balt	permit. Pag Department: IImportant: It any injury o		21. Signature of Funeral Service Licensee 23a. Pant Enter the disease, or complications that caused the	4 death. Do not ent	2. Name and Addres 217 9th. er the mode of dying	St. N.W.			20011 Approximate
8760,	Cate be executed / Medical Examiner and the burial-transit	dicai Examiner		consequence of): TAGE consequence of): halp consequence of):	kenal uttys (dise. Hepaki	se Isephic		Interval Between Onset and Death
O. Box 6	death certifi e attending p id for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tire	Fetal death 3	Ectopic pregnancy Other (specify)	1-10-10-10-10-10-10-10-10-10-10-10-10-10		23d. Date of del Month	ivery Day Year
cords, P.	requires the	by	Part II. Other significant conditions contributing to death but	not resulting in the u	ndertying cause give	en in Part I.	23e. Did tobace 1 ☐ Yes 24a. Was an	2 No 3 Pr	the cause of death? obably 4—Dinknown topsy findings available
Vital Record	Physiclan: The law this certificate has b al director, page 2 sl	Be Completed	25. Was case referred to medical examiner?		Othe	26. Place of Death	autopsy performed 1 Yes 2 (Check only one)	prior to death? No 1 □ Yes	20 No
Division of	Attending death. ictor: After y the fune	Certification: To	27. Manner of Death 1	Year) 28b. Time of Injury	28c. Injury Work M 1 🗆 Y	at :? /es 2 \(\subseteq No	ne 5 Residence 28d. Describe how in 28f. Location (Stree City or Town, S	njury occurred t and Number or Ru	
)	To the Hospital or within 24 hours after To the Funeral Die completely filled in b	edical	29a. Certifier (Check only one) Certifying Physician: To the best of 2 Medical Examiner: On the basis of e and manner state	xamination and/or in	vestigation, in my op	pinion, death occurre	ed at the time, date	and place, and due	to the cause(s)
)	Con With	W	29b. Signature and title of certifier 30. Name and address of person who completed cause of dea		,	403		Date signed (Monti	6
	Sta Regista		30. Name and address of person who completed cause of dea SURESH IC, KHETAN, MD, 7610 31. Date filed (Month, Day, Year) 32. Registrar' JAN 1 9 2006	S Signature	AVE#260	TAKOMI	PARKI	MD 2091	2

			1 - For State Registrar	State of Marylar				lealth a	and Me		giene	006	00972
	Physici /Medic	- 27	1. Decedent's Name (First, Middle, La							2. Date of Dea Month	Day	Year 200	3. Time of Death
	Examin		4a. Facility Name (If not institution, given BACT'INCRE - WAS) 5. Social Security Number 6.5	INCTON MEDICAL		CI	Town, or EN or 1 Year	BURN If Under	of Death		4c. Co		J3Q NU-
ì	Funeral Director			x M 2□ F 49	Yrs.	Months	Days	Hours	Min.	8. Date of Birti (Month, Da) Nov. 19	, ^{Yea} r) , 195	66 Mai	hplace (State or Foreign ountry) Cyland
	the Maryla 28a-f ehov	rector	Maryland Anne An		asaden	a	ip Code				10a Citize	n of What Co	10d. Inside City Limits 1 Yes 24 No
	h with	i Di	8292 Railroad	Avenue			211	22				S.	
5-0036	filed within 72 hours after deeth with the Maryland Hygiens. After than "naturel", or Iteme 23a or 28a-f ehow ent, the Madical Exam are munt be motified a	by Funeral Directo	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 21 No If Yes, Give Year or Dates:			_	ispanic Origin, Mexican	gin? (Spec I, Puerto F	cify Yes or No- lican, etc.)		Race - Ame Black, Whit	e, etc.
0-6121	within 72 ho ene. than "natur ne Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 8th		16a. Dece (Give life. Self		ual Occup ork done d use retired		of workin	g		of Business	Industry & Painter
Maryland 2	b d la b	To Be Co	17. Father's Name (First, Middle, Last	oh T. Giles						(First, Middle, Hutchin	Maiden St		u rumer
_	alith a		19a. Informant's Name/Relationship (Constance V. Rig	ney / sister	417	Bon .	Air R			Route Numbe			Zip Code) 1 21225
altimore,	nit. Pages 1 and bertment of Healt fortant: if Item 2' injury or other 2'		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	Place of Dispo cemetery, crei yview (natory or	other place	:e)	1/20/	2006		tion - City or imore,	Town, State Maryland
Balt	permit. Pag Depertment Important: eny injury o		21. Signature of Funeral Service Lice	remusiul.	4(2. Name a	and Addres	ss ol Facilit ie Hi	^y Gor ghway	nce Fun Balt	eral imore	Servic , Mary	e, P.A.
	Physician /Medical		23a. PM1. Enter the disease, of conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the dear one cause on each line. a	74 Di						rest,		Approximate Interval Between Onset and Death
8760,	rate be executed by the horial-transit and the burial-transit and th	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect c. Due to (or as a consect d.	quence of):	T43	TAVI	ion ?	4 4	DEONE		4	2443F OF
P.O. Box 6	or Attending Physicien: The law requires that the death certificate Iter death. Director: After this certificate has been signed by the ettending phys in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	al déath 3[Ectopic Other (pregnancy specify)				230	d. Date of del	ivery Day Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions	_	sulting in the u	nderlying	cause giv	en in Part I.		1	bacco use		the cause of death?
Division of Vital Records,	hysicien: The law re his certificate has be I director, page 2 sho	Completed								24a. Was autop perfor	med?	prior to death?	itopsy findings available completion of cause of 2 X No
<u> </u>	certifi	Be C	25. Was case referred to medical examiner?	Hospital:	150/0		Oth			(Check only o			
ion of	Attending Physist death. ector: After this by the funeral di	ation: To	1 Yes 2 No 27 Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		28c. Injur	4 🗀 140	2	le 5 ☐ Resid 8d. Describe h			cify)
Divis	s after des	Certification:	3 Suicide 6 Could not to determined		iome, larm, sti fy)	reet, facto	ry, office		2	8f. Location (S City or Tow	Street and t m, State)	Number or Ru	ural Route Number,
	To the Hospitel or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical Exa	hysician: To the best of my knimer: On the basis of examination and manner stated.	owledge, deat ation and/or in	vestigatio	n, in my o	pinion, dea	d place, a th occurre	d at the time, o	date and pl	ace, and due	to the cause(s)
	Neith To To To To To To To To To To To To To	Σ	29b. Signature and title of certifier			2	9c. Licens		. 1.		29d. Date s	signed (Monti	h, Day, Year)
	>		30. Name and address of person who		m 23a) (Type,	Print)	poo	e 7 ±	14	1.	UMAL	ARY	2006
		ate	Dr. Guillermo G	32. Registrar's Sign		40		e G	len E	Burnie,	Mary	land 2	1061
1	Regist	rar	JAN 1 9	2006	13 6	12305	The state of the s						

			For State Registrar	icasc	State o	f Marylar			t of H	lealth a		•	giene	nna	00973
- 3			Hegistrar Decedent's Name (First,	Middle. Lasi	')			incat	0 0/ 1	Jean		2. Date of De	Reg. No.	000	3. Time of Death
	Physicia	an	LOUIS		,		4	UGH	-5			Month	Day	Year 2001	
100	/Medic		4a. Facility Name (If not insi		street and nur	nher)				Location of		JANUA		County of Dea	
	Examin	٠,					^							SALTIC	
	E		5. Social Security Number	5 PAY1		7. Age (In yrs.			1 Year	If Under		8. Date of Bir			
	Funeral Director		219-22-3059	1	☐ M 2[XF	7		Months	Days	Hours	Min.	8. Date of Bit (Month, Da May 21	19, Year)		rthplace (State or Foreign ountry) 110
	4.		Usual Residence of Decede	int				11				inay 21	, 1020	, <u>()</u>	110
	ylan		10a. State 10b. C	ounty		10c. C	ity, Town or Lo	ocation							10d. Inside City Limits
	Mar Med	tor	MD Bal	timor	е		Dundall	2							1 ☐ Yes 2 X No
	or 28	Director	10e. Street and Number					10f. Zip	Code				10g. Citize	en of What C	ountry?
	23a c	a	3437 Liberty	Park	way				2122	22			US	SA	
	dea	ner	11. Marital Status		12. Was Dece Armed Fo	edent Ever in U	J.S. 13.	Was Dece	dent of Hi	ispanic Ori	gin? (Spe	cify Yes or No Rican, etc.)	D- 14	4. Race - Am Black, Whi	erican Indian,
ဖွ	after or it	F.	1 Never Married 2		1 ☐ Yes If Yes, Giv	2 No		1 ☐ Yes		Specify:				Specify: W	
8	ural',	d b	3 X Widowed 4 □ Div	orced	Year or D	ates:			-X						
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23s or 28e-f show ent, it a Mudical Evani, ar must be notified at	Completed by Funeral		cedent's Ed highest grad	ucation de co <i>mpleted)</i>		(Give	dent's Usua kind of wo	rk done d	during mos	t of workir	ng	16b. Kin	d of Business	s/Industry
<u>2</u>	vithin ne. han	ш	Elementary/Secondary (0)-12)	College (l-4or 5+)		DO NOT u		3)				0	
2	lled v lygie ther t		12 years 17. Father's Name (First, M	iddle (set)			Sec	retar	У	19 Mothe	ar'e Name	(First, Middle		gn Com	oany
JUE	be f d of	Be		Iddie, Last)								ıjardir		ourname)	
Ž	d Me d Me nark natio	2	Roy Wright	ationahia /7	ima Deinel		10h Maili	- Add	(Ctroot)					Tour State	Zin Codel
Maryland	12 st h and 7 is n treun		19a. Informant's Name/Rel					-				i Route Numb ndalk,			
e,	1 and Healt	1	William J. H	lugnes	Jr.	son 20b.	Place of Disp			Road		ate			r Town, State
Ö	if of h		1 ☑ Burial 2 ☐ Crem			State	cemetery, cre	matory or o	other plac	· 1	Janua	ary			
Ë	tmer tant		4 Donation 5 Dot	THE RESERVE OF THE PERSON NAMED IN	-	MO	st Hol				1, 20			imore,	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: if item 27 is marked other than "natural", or items 23a or 28e-1 show important: if item 27 is marked other than "natural", or items 23a or 28e-1 show in my injury or other treumatic event, if a Medical Evan in must be notified at QRICs.		21 Signature of Funeral So	rvice Licen	(h		2	Conne 7110	11y	Funer ers P	al Ho	ome Of Road,	Dunda Dunda	alk,P. alk,MD	A. 21222
			23a Part 1 Enter the disea shock or heart failure	se, or comp	olications that o	aused the dea	ith. Do not en	ter the mod	de of dyin	ng, such as	cardiac o	r respiratory a	ırrest,		Approximate Interval Between
11.0%	Physician		Immediate Cause (Final disease or condition		. P.	FORA	TED	Du	っトド	NOIN	7				Onset and Death
	/Medical		resulting in death)			(or as a conse									
*	Examiner		Sequentially list conditions		b										
	D #	Examiner	Sequentially list conditions day, leaving to immediate cause. Enter Underlying Cause (Disease or injury	1	Due to	or as a consa	quence of):								
	and trans	am	that initiated events resulting in death) Last	1	c										
760,	ate be executed hysicien and he burial-transit		, , , , , , , , , , , , , , , , , , , ,		Due to	(or as a conse	querice or):								
87	icate t physic s the b	dicai			d										
x 68	death certifica e ettending ph id for use as th	Physician/Med	IF FEMALE:		00- 16										
Вох	ath c	lan	23b. Was decedent pregna in the past 12 months			irth 2 🗆 Fet	al death 3	⊒Ectopic p		,			23	3d. Date of de Month	olivery Day Year
<u>o</u> .	the e	/sic	1 ☐ Yes 2 🔀 No 9 ☐ Unknown		4∐Pregr 9☐Unkn	nant at time of own	death 5	Other (s	oecrfy)	·					,
<u>G</u> .	requires that the death een signed by the ette hould be detached for	Ph	Part II. Other significant c	anditions o	antabuting to d	eath but not re	eulting in the	underhing (cauce on	en in Part I		23e Did	tobacco ue	e contribute	to the cause of death?
Records,	S D 0	b	RESPIRAT							off art art i	•				Probably 4 Unknown
5	w require been si	ompieted	THE SPIRIT	31-4	TIOP C	TILDI	70 12	200,							
ec	The faw ste has b bage 2 si	npie										24a. Was	psv	prior to	autopsy findings available completion of cause of
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of Vital	Physicien: T this certificat ral director, pa	Be	25. Was case referred to n examiner?	nedical	Harrier P		-		100		of Death	(Check only	one)		
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		o		Pending		of Injury th, Day Year)	28b. Time of Injury		28c. Injur Wor	k?	}	28d. Describe	how injury	occurred	
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	To the Hospitei or within 24 hours after To the Funerei Dir completely filled in	Med	29b. Signature and title of	oftitier	7/	/		29	c. Licens	e number			29d. Date	signed (Mor	nth, Day, Year)
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	7 0		30. Name and address of	person who	completed cau	se of death (Ite	em 23a) (Type	, Print)					- MINE	1ATLY	16,2006
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g(7)	Sta	ate	31. Date filed (Month, Day	Year)	32. 1	EAST	nature	1	16 m			-/1			+
	Regist	rar	J	AN1	2006	Magner	its.	A STATE OF	The state of the s						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** January 17, 2006 Year Richard M. Hashagen 6:15 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre De Grace Harford If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) June 20, 1918 9. Birthplace (State or Foreign **Funeral** Days 1**X** M 2□F 218-10-0804 87 Yrs. Mary land Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant if item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Completed by Funeral Director Mary land Cecil Conowingo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21918 416 Ragan Road USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 10 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married timore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Production Aircraft 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard L. Hashagen Blanche E. Schultz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth R. Newell/Stepdaughter 135 St. Judes Lane Conowingo Maryland 21918 other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🂢 Burial 2 🗆 Cremation 3 🗆 Removal from State ŏ Department of Important: If any injury or once. Meadowridge Memorial Jan. 20, 2006 Elkridge Maryland * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Christina L. Hilton 2. Name and dr. s of Facility Leynard J. Ruck, Inc 5305 har furti Ruad b hustina Baltimore Maryland 21214 23a. Part1. Enter the disease, or complications that of used the death, shock, or heart failure. List only one cause on each line. Dynyt enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) nal /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Other significant conditions confributing to death, but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 No Division of Vital Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify, Medical Certification: To 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident hours after deat 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 | Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and the 29c. License number

State Registrar q

DHMH 17 Rev 1/2001

person who completed cause of death (Item 23a) (Type, Print

32. Registrar's Signature

			1 - For State Registrar	State of	Marylan	-	artment <i>tificate</i>			ind M	ental Hyg	giene ()	06	00975	
	Physicia /Medic		1. Decedent's Name (First, Middle, Las Lloyd Edward Ha	•	Jr.						2. Date of Dea Month January	Day	Year 2006	3. Time of Death	
	Examin		4a. Facility Name (If not institution, give	street and numb	per)		4b. City,	Town, or	Location o	f Death			ty of Death	1	_
			Eastpoint Nursi		Rehab			Ess				Ва	altime	ore	
	Funeral		5. Social Security Number 6. So	x 7 XM 2□F	. Age (In yrs. 61	last birthday): Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day	, Year)	9. Birth	place (State or Foreign intry)	,
	Director	}	214-40-9885 Usual Residence of Decedent		01	115.					Apr. 17	7, 1944	Ma	aryland	_
	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits	_
	Mary I sh	to	MD Balt	imore	1			Edge	mere				ĺ	1 ☐ Yes 2 🛣 No	
	h the	Director	10e. Street and Number				10f. Zip				1	10g. Citizen of	What Cou	untry?	_
	th wit	aiD	7213 North Point	Road				2	1219						
	r dea	ner	11. Marital Status	12. Was Deced Armed Ford	es?	.S. 13.	Was Deced	ent of His	spanic Oriç n, Mexican	gin? (Spe , Puerto F	cify Yes or No- Rican, etc.)	14. Ra	ace - Amer ack, White	ican Indian,	
36	within 72 hours after death with the Maryland ene. then 'natural', or items 23e or 28e-f show re Modicel Examitter in ust be motified at	by Funerai	1 Never Married 2 Married 3 Widowed 4 Divorced	1 XYes 2 If Yes, Give	1.0	965+	1 X Yes 2		Specify:			Spec		hite	
Ş	hour tural		15. Decedent's Ed	Year or Dat	es: 15	16a. Dece	lent's Usua	I Occupa	tion			16b. Kind of I			_
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<u> </u>	should be and Mental marked o	To	Lloyd E. Hartzell						Bes	sie :	E. Ston	esifer			_
Maryland 21215-0036	2 sho		19a. Informant's Name/Relationship (•				Route Numbe			ip Code)	
	ges 1 and 2 should be filed within 72 hours after death with the Marylar at of Health and Mental Hygiene. If Item 27 is marked other then *natural; or Items 23a or 28a-f show or other treumatic event. It a Modical Examiltar is used by coeffied at		Brent A. Hartzell 20a. Method of Disposition	., Sr.	Son	_ 10 G: Place of Dispo			Lane		kton, M				_
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Ba	permit. Pages 1 and 2 Department of Health a Important: If tem 27 is any Injury or other tre ance.		Man on in O		VII	11201				A	mbrose				
	.#		23a. Part1. Enter the disease, or com	olications that car	used the deat	h. Do not ent	er the mode	e of dying	ar Sp , such as	cardiac o	Rd., A	rbutus rest,	, MD	Approximate	
	Pnysician		shock, or heart failure. List only Immediate Cause (Final disease or condition	-	Λ	55 /	ME	,,,-	Tr. 0	-			- 7	Interval Between Onset and Death	
	/Medical		resulting in death)	a. Due to (o	r as a conseq	uence of):	162		45						-
ï	Examiner		Sequentially list conditions,	b. HYA		ENS	101	\							
	b is	iner	cause. Enter Underlying Cause (Disease or injury	,	ras a nonsec				_	9					
	and and I-tran	Examiner	that initiated events resulting in death) Last	c. Due to (o	ONIC r as a conseq	uence of):	TRI	LCT	116	14	LMON	ARYD	ISEAS	E	_
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687	ficate p phys	edicai		0.5 5 7 6	7, 2		, .,	- // _		/		را عرب	_		
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	w requires that s been signed to should be deta	Completed by Physician/Me	Part II. Other significant conditions of	ontributing to dea	ith but not res	ulting in the u	nderlying ca	ause give	n in Part I.					the cause of death?	
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Records,	has b	mple									24a. Was a autop: perfor	an 24b	. Were aut prior to o death?	opsy findings available ompletion of cause of	
alF	Th ate pag										1 ☐ Yes	2010	1 Yes	2 No	_
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	nationt 2	ER/Outpatier	. a	Othe	r /		(Check only or			~	
ō	g Physer this eral di	n: To	27. Manner of Death	28a. Date of	Injury	28b. Time o		8c. Injury Work			ne 5 Resid			ity)	-
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Division	er der recto by th	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	289. Place	of Injury - At h	ome, farm, str	eet, factory	, office		2	28f. Location (S City or Tow		ber or Ru	ral Route Number,	
	ital or rs eft rel Di	Cer													
	To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: Affer th completely filled in by the funeral	edical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the base niner: On the base and manne	sis of examina	owledge, deat ation and/or in	n occurred vestigation,	at the tim , in my op	e, date and inion, deat	d place, a th occurre	and due to the co ad at the time, c	ause(s) and nate and place	nanner as , and due	stated. to the cause(s)	
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	ht		30. Name and address of person who	completed cause	of death (Iter	n 23a) (Type,	Print)		10	0		1"/			_
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-:	Examin	er					,		Park	or Doalii			Ontgom		
591.	Euparal	~	Washington Adv 5. Social Security Number 6		. Age (In yrs.	last birthday)	If Unde	r 1 Year	If Under		8. Date of Birth				te or Foreign
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ē	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28a-f show may injury or other traumatic event, the Madical Examiner must be notified at ance.		20a. Method of Disposition		20b. F	Place of Dispo	sition (Na	me of	1.		Date			or Town, State	
J10	Pages ment of I ant: if its ury or o		1 ☐ Burial 2 【XCremation 3 4 ☐ Donation 5 ☐ Other (Spe			cemetery, cres tropo1:		otner plac		1-21	-06	A1e	exandr	ia, VA.	
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62			23a. Part 1. Enter the disease, or co	emplications that ca	used the deat					_			, D. O.	Approxii	
	Dhusisian		shock, or heart failure. List or Immediate Cause (Final	ly one cause on ea	ch line.	TOA	001	رسي		1 1	N= 01	(/ n	04-	Oncot a	Between nd Death
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9	death certificate t a attending physic d for use as the b														
Вох	death certifica e attending ph id for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	ome of pregnath 2 Peta]Ectopic ∣	reanancy	,				23d. Date of	delivery	
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	The law requires that the tite has been signed by the bage 2 should be detache	by	Part II. Other significant condition	s contributing to de	ath but not res	sulting in the u	ınderiying	cause giv	en in Part I		23e. Did to	obacco u	se contribut	e to the cause	of death?
Records,	v require been si should I										1 🗆 Y	∕es 2l	□ No 3 □	Probably 4	Unknown
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n of			27. Manner of Death 1 Sylvatural 5 ☐ Pending	28a. Date o (Monti	f Injury n, Day Year)	28b. Time of	of	28c. Injur Wor	y at k?		28d. Describe h	now injur	y occurred		
3.0	eat or:	catio	2 Accident investiga				М	1 🗆	Yes 2□	No					
Division	2 th = c	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	280. Place	of Injury - At h g, etc. (Speci	iome, farm, st	reet, facto	ry, office			28f. Location (S City or Tox			r Aurai Aoute f	√um <i>ber</i> ,
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	To To		29b. Signature and title of certifier	5 477	en no	ry	2	ec. Licens	1 7	-	_	290. Dai	le signed (M	onth, Day, Yea (C) 6	"
7	-			D. CC.	usec.	o de		V 0		,0 1		0'	()(
	10		30. Name and address of person w	no completed cause	of death (Ite	m 23a) (Type	, Print)	20	00	2	ann	07	Con	Cert	91
1-			31. Date filed (Month, Day, Year)	32/10	egistrar's Sign	ature	/	NR	OV	11	Diese	N	mo	0	(10)
	St Regist	ate i rar	JAN 1 9	2006	PARL A	A AS	31/2	ý.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend item 5 per fh 8851 1-27-06 vt.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Month 24 AM ph ia MNHONY 50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Pital LIMON Good Samaritan HOS Ba Ltimor 13< If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. So**2152~32~7821** 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 10M 20F 212-32-7824 Director Usual Residence of Decedent death with the Marylene 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or itama 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Baltimore 1 Yes 2 No Director Imore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Handzerlia, Joseph 7RISTO PHER AVENUE USA 21214 70 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 12 fes 2 No If Yes, Give Year or Dates: 1957 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 end 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: It item 27 is marked other than "natural", or ital any injury or other traumatic svent, the Medical Examina once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) RRICR DERVICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Handzerlia JOSEDH 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, 1315 Dalfmere Mb 2/237 2 c. Location - City or Town, State IEEN HANGZER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 100 Dayriew Rematory: 22 Name and Address of facility Bradley- Ashton Funeral 21. Signature of Funeral Service Home, P.A Bradley-Ashton Fun 2134 Willow Spring m01455 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 0(2/04 5 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a cons uence of): Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed the burial-transit 26 SIS resulting in death) Last Due to (or as a consequence of): Box 68760 attending physicien Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy been signed by the atte should be detached for in the past 12 months? Year Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Dunknown Part II. Other significant conditions contributing to death, but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2)X No 3 Probably 4 Unknown Vic a cielosi 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an page 2 autopsy performe certificate 2 No 1 Yes funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 3□ DOA Certification: To 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural Injury after death. I Director: Af in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) letely filled in by determined 4 Homicide To the Hospital within 24 hours a To the Funeral L to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) m 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 6 6 1 och Kaven 1 alhore MALES 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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19-68.9

			For State Registrar	State	of Marylar			nt of H		nd Me		giene		00078
	3 °	- 40	Decedent's Name (First, Middle, La	(st)							2. Date of Dea	ath	U U	3. Time of Death
	Physicia		Martha Francis Holm	nes							Month JANUA	Py 17	ZOC I	6 11:40 AM
3	/Medic Examin		4a. Facility Name (If not institution, given		ımber)		4b. Cit	y, Town, or	Location of			4c. County	y of Death	
		18 18-2	Union Memorial Hospit	al				Baltim	ore				NA	
	Funeral			Sex 1 □ M 2 🐼 F	7. Age (In yrs.	• • • • • • • • • • • • • • • • • • • •	If Und Month	er 1 Year s Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Birtl (Month, Day	h y, Year)	9. Birth	nplace (State or Foreign
2/4	Director		215-14-0951		8.	3_ Yrs.					05-20-19	22	Mary!	
	land		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation							10d. Inside City Limits
	Mary fied	to	MD NA			Balt	imore	<u>!</u>						1XXYes 2 ☐ No
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	r dea	Funerai	11. Marital Status	12. Was Dec	edent Ever in U	J.S. 13.	Was Dec	edent of Hi	spanic Orig n, Mexican,	in? (Sper Puerto F	cify Yes or No- Rican, etc.)	14. Rad Bla	ce - Amer	rican Indian,
S .	s afte	by Fu	1X Never Married 2 Married 3 Widowed 4 Divorced	If Yes, G	ZX No ive			2 X No	Specify:			Specif	fy:	
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		Bec	17. Father's Name (First, Middle, Las.)		·			*	's Name	(First, Middle,	Maiden Sumai	-	
	D 6 9 0		Francis Holmes		<u>_</u>				Le	ena Wa	allace			
_	0 0 = 0	31.1	19a. Informant's Name/Relationship			1	_					r, City or Town		(ip Code)
_	s 1 and f Health item 27 other tr		Dawn Jones/ Granddaug	hter	20h				rcle AF			, MD 21:		
altimore,	@ Q b-		20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 [State	Place of Dispo cemetery, crea	matory o	r other place	1		ate	20c. Location	•	
	it. Pa		4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice		Kin	g Memori			O1 s of Facility	L-24-C)6	Randalls	town,	MD
ğ	permit. Page Department Important: It any injury or	M.	\$1	Jones							38 N Gi	Imor Str	oot B	alto, MD 21217
	165 E		23a. Part1. Enter the disease, or con	aplications that	caused the dea								SEL DO	Approximate
	hysician		shock, or heart failure. List only Immediate Cause (Final	A A		A	CAD	0515						Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to	(or as a consec	nuence of):								5 dens
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Вох	death d for	Clai	in the past 12 months?	4□Preg	birth 2 Feta nant at time of		⊒Ectopic ⊒ Other (pregnancy specify)					onth	Day Year
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Š.	w requires that been signed b should be dett	ьу Р	Part II. Other significant conditions	contributing to	death but not res	sulting in the u	ınderlying	cause give	en in Part I.		23e. Did to	bacco use con	tribute to	the cause of death?
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Division of	Atten r deel ector	fica	3 Suicide 6 Could not	h0	e of Injury · At h	nome, farm, st					8f. Location (S	Street and Num	ber or Ru	ral Route Number,
ă	s efte	Certification:	4 Homicide determined	build	ding, etc. (Speci	ify)					City or Tou	vn, State)		
	To the Hospital or Attending Physician: To the Funeral Director: After this cartification to the Funeral Director: After this cartification to the funeral director; completely filled in by the funeral director;	Medical (29a. Certifier 1 Certifying P	miner: On the I	basis of examin	owledge, deat ation and/or in	h occurre	ed at the tim	ne, date and pinion, death	d place, a h occurre	and due to the o	cause(s) and m date and place.	anner as	stated. to the cause(s)
	o the ithin 2 o the orphe	Med	one) 29b. Signature and title of certifier	and mai	nner stated.			9c. License				29d. Date signe		
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	1		30. Name and address of person who	completed cau	use of death (Ite	m 23a) (Type,	Print)							
1 10	2		JCAVITA I		Registrar's Sign		. U	NIO	NI	New	noriA	L Hi	Sfi	TAL, Mb.
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Henry W. Ireland Jr. 06-00377 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. CTState of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** January rel 2006 1:54/Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Johns Hopkins Hospital Baltimore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 10 M 2□ F -54-078 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehov f Heelth and Mental Hygiene. Item 27 ie marked other then "neturel", or iteme 23a or 28a-1 ehov other treumetic event, the Medical Examinar must be notified at Marylana f¥ Yes 2 No Directo more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funerai 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) man 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be on) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 170. 20a. Method of Disposition 20c. Location - City or Town, State \$ = 5 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Department Important: if eny injury or 2006 4 Donation 5 Other (Specify) tores: Son 22. Name and Address Joseph L. + 2222 W. N. 21. Signalur of Funeral Service Libensed Home, P.A. 23a. Parti Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** FO resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attanding physicien a for use as the burial-P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown peeu 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

124 yes 2 \(\subseteq \text{No} \) certificate 1 XYes 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 TXYes 2 No Malient 2 ER/Outpatient 3 DOA Director: After the 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation Deceased assau 1-13-06 1 ☐ Yes 2 XNo death. 22:11PM 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours aftar d To the Funeral Direct completely filled in by 4 Homicide Bradford 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medicai The certifying Privateur: To the dest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainteness stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DHMH 17 Rev 1/2001

State Registrar 29b. Signature as

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

111 Penn Street

29c. License number

OCME

29d. Date signed (Month, Day, Year)

January 15, 2006

Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2006 **Physician** Inskeep January 15, 1:15 P M Eugenia /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gwynn Oak 1415 Langford Road If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔽 F Months Director 213-14-9563 Baltimore, MD. 85 October 8,1920 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 7 is marked other then "naturel", or items 23s or 28s-f show treumatic svent, the Mudical Exercit erroust be notified at 1 ☐ Yes 2 X No Director Gwynn Oak Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21207 USA 1415 Langford Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filled within 72 hours after nent of Health and Mentat Hygiene. ant: If Item 27 is marked other then "naturel", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Electronics Supervisor 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rosario Altomare Guiseppe Giordano 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter Virginia J. Inskeep 1911 Robinwood Road, Dundalk, Maryland In-Law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State January 1 \ Burial 2 \ Cremation 3 \ Removal from State 4 \ Donation 5 \ Other (Specify) 5 Department of important: If sny injury or once. Sacred Heart of Jesus Cem. | 19, 2006 Dundalk, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Connelly Funeral Home Of Dundlak, P.A.
7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part 1. Enter the disease, or complications that caused the teath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARCENOMA **Physician** 44N6 1/2 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine been signed by the ettending physicien and should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) Yes 2 No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes certificate 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) ۵ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this completely filled in by the funerel 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D22114 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ONDINE E, BERCHESS 060 PRIEDBACK SULTRIB, BALYIMORE, NO RD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Barbara S Registrar

			For State Registrar	State of Maryla		artment of F tificate of I			eg. No.	6	009	186
			Decedent's Name (First, Middle, Last)					2. Date of Deat	th		3. Time of	Death
	Physicia /Medic		LEROY R. J.	ones JR				January		Year 006	8:07	рΜ
	Examin	_	4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or	Location of De		4c. County of	000	0.01	
			2761 Baker Street			Baltime			N/A			
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs	. last birthday)	If Under 1 Year Months Days	If Under 24 H Hours M	n. (Month, Day,	Year)	9. Birthpla	ce (State o	r Foreign
	Director		219-50-2396 Usual Residence of Decedent	56	Yrs.			APR. 4	1949		MO	
	and and		10a. State 10b. County	10c. C	ity, Town or Lo	cation				100	d. tnside Ci	ty Limits
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	r 28.	Director	10e. Street and Number		12111111	10f. Zip Code		1	0g. Citizen of Wh	nat Country	y?	
	23a o	alD	2761 BAKER.	ST.		2	1216		4.5.	Α.		
	ems ems	Funeral		12. Was Decedent Eyer in I		Vas Decedent of H	ispanic Origin?	(Specify Yes or No-		- Americar White, etc.		
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5	hour lurei'	q pa	3 Widowed 4 Divorced	Year or Dates:	100 David	tanta Harat Occur		1				
2	filed within 72 hours after death with the Maryland Hygiene, Hybrine, or Items 23a or 28a-f show the Item Medical Examination motified at	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give	lent's Usuat Occup kind of work done o DO NOT use retired	during most of w	vorking	16b. Kind of Bus			
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3	should be ind Mental marked c	To B	LEROY Jones	SR.			Dele	RES JO	nes			
_	s 1 and 2 should be filed within 72 hours after death with the Marylan Height and Mental Hygiane. The state 23a or 28a-f ehow filem 27 is marked other then "naturel; or Items 23a or 28a-f ehow other treumatic event, the Medical Examiner must be mortified at	Ţ	19a. Informant's Name/Relationship (Ty)	pe, Print)	19b. Mailin	g Address (Street	and Number or	Rural Route Number	, City or Town, S.	tate, Zip C	ode)	
2	and lealth m 27 her tr		Michelle Johnson	n. Daughte	٧ 45		ege LN		HALL 1	MD. 0	11128	>
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2	permit. Departr Importe eny inju		21. Signature of Fonerat Service License	Prois)	No.	ichael 2	iglier F	un Svc P. Ave, BAH	H. MA O	1919		
			23a. Part1. Enter the disease, or comple	cations that caused the dea	ath. Do not ente	er the mode of dyin	g, such as card	iac or respiratory arre	est,	A	pproximate	ə
F	Physician		shock, or heart failure. List only of Immediate Cause (Final		- 05	MAI D.	-				nterval Bety Onset and D	
	/Medical		disease or condition resulting in death)	Due to (or as a conse		MAL DIS	672					
	Examiner		Sequentially list conditions,									
_	Si od	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):							
	and I-tran	xam	that initiated events resulting in death) Last	Due to (or as a conse	Quence of):							
3	icate be executed physicien and s the burial-transit			D00 10 (01 a3 a c0130	querice or).							
	ficate physics the	edicai										
5	nding use a	N/M	tF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregr		-			23d. Date	of delivery		
3	death e atte	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fet 4 Pregnant at time of		Ectopic pregnancy Other (specify)			Mont			'ear
•	at the by th	Physician/M	9 Unknown	9 Unknown								
ກົ	ires that the death certifications signed by the attending doetached for use a	þ	Part tl. Other significant conditions con	tributing to death but not re	sulting in the ur	nderlying cause give	en in Part t.		pacco use contrib			
5	w requir been si should	Completed						1 □ Ye	s 2 🖳 Ko 3	Probab	oty 4 □U	nknown
טַ	a jaw has b a 2 st	nple						24a. Was a	y pri	ere autops or to comp	y findings a	ivailable ause of
5	cate	S						perform		ath? Yes 2	□ No	
	ician certifi rector	Be	25. Was case referred to medical examiner?	lospital:		Othe		eath (Check only on				
5	Phys rat di	. T	2∑Yes 2 No 27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	28b. Time of	1 3 DOA	4 U Nursing	Home 5 ☐ Reside			Scene	ة َ
5	ding th.: Afte	tion	1 SNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	28c. Injun Work	(?` Yes 2 □ No	20d. Describe no	w injury occurred	,		
2	Atter or dea ector by the	ertification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At	home, farm, stre			28f. Location (St	reet and Number	or Rural F	Route Numi	ber,
5	tai or s afte at Dir ed in	Cert	4 - Hombide	building, etc. (Spec	ary)			City or Town	n, State)			
	Tuner funer	edical	(Creck only XX Medical Examil	sician: To the best of my kr	nowledge, death	occurred at the time	ne, date and pla	ce, and due to the ca	ause(s) and manr	ner as state	ed.	
	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours attendeath. To the Funcial Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. License						
	¥ ₹ 8	_	A COLUMN TO CONTROL OF	(No 00 1	1.0				9d. Date signed (,	
6			30. Name and address of person who co	0 00-	M)		OCME		January	15, 2	.006	
4	-		4 13 7 7	LDR GU	m 234) (1998, I	- 1	n Stree	t Baltim	ore, Mar	vland	1 2120	01
_			31. Date liled (Month, Day, Year)	32 Registrar's Sign					,	Jacine		

Vincent Jordan Sr. 06-00430 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. MUN State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month January 2006 1451 Vincent Lee Jordan, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner n/a Johns Hopkins Bayview Baltimore
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1(**X**M 2□ F Director 56 January 7,1950 Maryland 216-54-5876 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at 1 Yes 2 No Directo Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21227 5642 Carville Avenue United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🛛 No Specify: ۵ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) fishing/crabbing 12 commercial waterman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental 27 is marked or traumatic ever Muriel Catherine Milan Winfred Colin Jordan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other trains 5642 Carville Avenue, Baltimore, Maryland 21227 <u>Linda Lee Jordan – wife</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition January 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Depertment Important: eny injury conce. Loudon Park Cemetery 21, 2006 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Puneral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. Kowe 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Drowning complicated by athoroschootic cardiovescular disease and hypothermia **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the deeth certificate be executed physicien and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical ettending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 □ No cete hes t page 2 s 1 Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ XXYes 2 No 2XXER/Outpatient 3 □ DOA (his After this 28c. Injury at Work? 28d. Describe how injury occurred in baching 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of Certification: 1 Natural
2 Accident
3 Suicide 5 Pending Injury 2:00 PM accident 1 ☐ Yes 2 No death. investigation 1117/06 Director: 281. Location (Street and Number or Rural Route Number. City or Town, State) 1300 NEW GETE - FORT MEMERITY & Chesoperke, Bry Chronil, Butt., M) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours eft To the Funerel Di completely filled in uliter way Medical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29c. License numbe 29d. Date signed (Month, Day, Year) **OCME** January, 18, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E. Southail, mD remela 111 Penn Street Baltimore, Maryland 21201

State

Registrar

31. Date filed (Month, Day, Year)

JAN 1 9 2006

32. Registrar's Signature

			State of Maryland / Department of Health and	d Mental Hy	giene
			Registrar Certificate of Death		Reg. No. UUD UUJOJ
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Dea	Day Year
The same	/Medic			JANU.	4C. County of Death
	Examin		D:I		Anne Arundel
- 1	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Tunder 1 Year If Under 24 H	Hrs. 8. Date of Birt	th 9 Birthplace (State or Foreign
	Director		219-12-5730 1MM 2 N 80 Yrs. Months Days Hours M	Min. (Month, Da 02/21	/1925 Country) MD
	DG &		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		
	arylan •how	ō			10d. Inside City Limits 1 ☐ Yes 2 No
	28a-1	Director	MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code		10g. Citizen of What Country?
	Mith Sa or	٥	7761 Central Avenue 21122		U.S.A.
	death ms 2:	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1.0.4.2 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu		- 14. Race - American Indian,
9	or Ita	T.	Armed Forces? 1 Never Married 2 Married 2 Married 1 Never Married 2 Married 2 Married 2 Married 2 Married 2 Married 2 Married 2 Married 2 Married 2 Married 2 Married 2 Married 2 Married 2 Married 2 Married 2	uerto Rican, etc.)	
5-0036	72 hours affer death with the Maryland natural; or Items 23a or 28a-f ehow deat Exacteur deat be notified at	d by	3 ☐ Widowed 4 ☐ Divorced Specify: 1946 1 Yes 2 No Specify:		Specify: White
5-	"nate	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)	working	16b. Kind of Business/Industry
2121	filed within Hygiene.	d L	Elementary/Secondary (0-12) College (1-4or 5+) Automobile Salesi	[Automotive Retail
	Hygid Other ent,	Be Co		Name (First, Middle,	
lan (ould be Mental arked o	To B	Ashby Lee Jenkins, Sr. Lore	tta Leek	
Maryland	2 should the and Menical sumation	1 3	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or	Rural Route Numbe	er, City or Town, State, Zip Code)
	# 23 ₹ d		Helen Jenkins / Wife 7761 Central Aver	nue, Pas	adena, MD 21122
Baltimore,	0 0 = =		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
Ë	Pa nen nrt: ury	١,	4 Donation 5 Other (Specify) MD Veteran's Cem 01,		Crownsville, MD
3al	permit. Departn Importe eny Inju				e Funeral Home, PA
	403 e d	7			sadena, MD 21122
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line. Immediate Cause (Final	diac or respiratory ar	rest, Approximate Interval Between Onset and Death
	Physician /Medical	î	disease or condition resulting in death) a. My o coadical in the coadical in	action	n hours
400	Examiner		Due to (or as a consequence of): Type 10 (or as a consequence of):		
		Jer			years
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events c.		
ó,	afe be executed hysician and the burial-transit				
8760	cafe b	dicai			
9 ×	ding passe as	/Me	IF FEMALE: 230 If was outcome of programme		
Вох	leath certifica affending ph I for use as th	ian	23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delivery Month Day Year
P.O.	at the de by the a fached	Physician/Med	1 Yes 2 No 9 Unknown 9 Unknown 5 Other (specify)		
σ.	res that igned b be defa	by Pr	Part II. Other significant conditions continuiting to death but not resulting in the underlying cause given in Part I.	23e. Did to	obacco use contribute to the cause of death?
Records,	w require: been sig should bo	ed b	Diatetes mellitus	1 D Y	res 2 k No 3 Probably 4 □Unknown
၀၀	aw re is bee 2 sho	plet	It oper tou sion	24a. Was	
Ä	The lay	Completed		autop perfor 1 ☐ Yes	rmed? death?
of Vital	ysician: The is certificate hi director, page	ВеС	25. Was case referred to medical examiner? 26. Place of E	Death (Check only o	
<u>></u>	hysic fhis co	P.	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cther. 4 Nursin	g Home 5 ☐ Resid	dence 6 ☐Other (Specify)
'n	ding Phy h. After fhi funeral	lon:	27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28c. Injury at Work?	28d. Describe h	now injury occurred
Division	death death otor: / fhe	icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	29f Location (6	Street and Muschary Court Court of
Ō	affer affer Dire	Certification:	4 Homicide determined building, etc. (Specify)	City or Tow	Street and Number or Rural Route Number, vn, State)
	spite hours merel y filled			ace, and due to the	cause(s) and manner as stated.
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funere IDirctor: After this certificate has been signed by the aftending physician and completely filled in by the funeral director, page 2 should be defached for use as the burial-transit	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death or and manner stated.	ccurred at the time, o	date and place, and due to the cause(s)
	with To t	Σ	29b. Signature and title of certifier 29c. License number		29d. Date signed (Month, Day, Year)
	١		1 (has there a MD D 2428	35	January 15 2006
1	XX		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	S. cula	Jeenvary 15 2006 STADT rive Glen Bernie HD
V)			spital D	rive Glen Bornie MD
1200	Sta	ite ar	IAN 1 9 2006	~	

	200		1 - For State Registrar	State of M	laryland		artmen rtificate			and M		giene leg. No.	006	009	184
	Physici	an	Decedent's Name (First, Middle, La	-							2. Date of Dea Month	Day	Year	3. Time of	
	/Medio Examin	al	RAY C. JOHNSON, 4a. Facility Name (If not institution, gi FUTURECARE CHESA)	ve street and number	·)		4b. City,		Location o	of Death	JANUAR	4c. Co	2006 unty of Death		A M
	F				ge (In yrs. la	ast birthday)	If Under		If Under	24 Hrs.	8. Date of Birt		IE ARUI		r Foreign
· *	Funeral Director			1 ∑ M 2□F	65	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da) AUG. 5	1940	WEST	place (State o intry) VIRGI	NIA
	Maryland f show	tor	10a. State 10b. County MARYLAND ANNE ARI	JNDEL		Town or Lo								10d. Inside Ci 1 ☐ Yes	
	r 28m	Director	10e. Street and Number				10f. Zip	Code				10g. Citizen	of What Cou	intry?	
	23e c	aiD	1100 SOMERSET DR	IVE			210	61				UNITE	D STAT	TES	
21215-0036	72 hours after death with the Maryland natural', or items 23a or 28a-f show final Examination with the multified at	by Funerai	11. Marital Status 1 □ Never Married 2 🛣 Married 3 □ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 Tes 2 X If Yes, Give Year or Dates	?] No		Was Deced If Yes, spec 1 ☐ Yes		spanic Ori n, Mexican Specify:	gin? (Spo i, Puerto	ecify Yes or No- Rican, etc.)		Race - Amer Black, White ecify: WH		
5-0	72 hours "natural",	eted	15. Decedent's E (Specify only highest gi			16a. Dece	dent's Usua kind of wor	al Occupa	ation Jurina mos	t of work	ina	16b. Kind o	of Business/I	ndustry	
121	be filed within 72 ho ital Hygiene. id othar than "natur avant, the Middieal	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	STAFF	DO NOT us	e retired)		9	CTTTT	LIODEE	DO INT	ONT
	il Hygie othar t	e Co	17. Father's Name (First, Middle, Las	t)		SIAFF	KEPK	ESEN			e (First, Middle,			ERS UNI	ON
Maryland	Mental Merked o	To Be	RAY C. JOHNSON,								RIE EVAN		name,		
ary	s 1 and 2 should t i Health and Ment item 27 is marked other traumatics		19a. Informant's Name/Relationship	(Type, Print)	-	19b. Mailin	ng Address	(Street a	and Numbe	or Or Rura	al Route Numbe	r, City or To	wn, State, Zi	p Code)	
	and 2 ealth m 27 her tr		MARY ELLEN JOHNSO	ON / WIFE	001 01				DR.,		EN BURNI				
Baltimore,	0 0		20a. Method of Disposition 1 Burial 2 Cremation 3		9 00	ace of Dispo	natory or o	ther plac		JANU	JARY 19		on - City or T		
Ħ			4 ☐ Conation 5 ☐ Other (Spec		MET	ro cr	Name an	d Addres	s of Facilit	v	006			, MARY	LAND
Ba	permit. Departn importe eny inju		Attalle			K	IRKLE	Y-RU	DDICK	(Ful	NERAL HO	ME, P	A.	21061	
	*		23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that cause	ed the death.								11, 11	Approximate Interval Bet	
À	Physician		Immediate Cause (Final disease or condition	a a	one	u	mo	n	نف					Onset and I	
100	/Medical Examiner		resulting in death)	Due to (or a	s a consequ	ience of);		•						/	-
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/	ate be executed hysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	con	elso	0 VC	ر کرد	N	ar	0	liseo	B	٤	year.	20
oʻ	e exec ian an urial-tr		resulting in death) Last	Due to (or a	s a consequ	ence of):			-						
8760,	icate by physic s the bi	dicai		d											
.O. Box 6	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rat director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal	déath 3[Ectopic pro					23d.	Date of delive	,	Yea r
<u>α</u>	res that the signed by be detact	by Phy	Part II. Other significant conditions	contributing to death	but not resu	Iting in the u	nderlying c	ause give	n in Part I.		23e. Did to			the cause of d	leath?
ord	w requir been si should	eted	13 Chemic	orwor	wyo	pou	2	10	JJ	_	1 🗆 Y	es 2 N	o 3 Pro	bably 4	nknown
al Records,	ysician: The law is certificate has b director, page 2 si	Completed	dementi	a de	alo	a C	an D	Pu	roun	(Q)~	24a. Was autop perfor 1 Yes	sy	4b. Were aut prior to co death? 1 \sum Yes	opsy findings ompletion of ca 2 No	available ause of
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οt	ig Phy ter this neral c		27. Manner of Death	28a. Date of In	urv	28b. Time o		8c. Injury Work		1	28d. Describe h			Ty)	
sior	들는동화	atlo	Natural 5 Pending investigate	on	ay roar)	приту	М		res 2 🗌	No					
Division	or Att fter de Diract in by t	Certification:	3 Suicide 6 Could not 4 Homicide determine	280. Place of I	njur y - At hor atc. <i>(Specify,</i>	me, farm, str	eet, factory	, office			28f. Location (S City or Tow		umber or Rui	al Route Num.	ber,
	spital ours a serai (29a. Certifier M Certifying P	hysician: To the bes	at of my know	vledge deat	h occurred	at the tim	o data an	d place	and due to the		4 =	-1-1-1	
	To the Hospital or Attant within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Exa	miner: On the basis and manner s	of examinati	ion and/or in	vestigation,	in my op	pinion, dea	th occurr	ed at the time,	date and pla	ce, and due	lo the cause(s)
	To th withir To th comp	Ž	29b. Signature title of certifier	· Me	3-		290	License	number			29d. Date si	gned (Month,	Day, Year)	
	1		Allen	-0				U	719	3/			ハノチ	90	
	100		30. Name and address of person who	completed cause of	death (Item	23a) (Type,	Print)	60	1.0	His	hu A	204/	wellen	Sille	un
8	Sta		31. Date filed (Month, Day, Year) JAN 1 9 201	32. Regis	trar's Signati	ure A	N. a	حر ر	ary	7		7		21108	
4	Regist	ar	JAN I 9 200	10 Algeria	o Si	A 3084	14								

			1 - For State Registrar	State	of Maryl	and / Depa	artmen rtificat	t of H e of L	ealth a Death	and M	lental H	/giene G Reg. No	9 0	6	009	986
8	Dhysisi	-	1. Decedent's Name (First, Midd	lle, Last)							2. Date of D	eath Da	,	Year		of Death
	Physici /Medi		Charles	Willi	ams		Kilby				January			006	7:0	1Р м
	Examir		4a. Facility Name (If not institution		ımber)		4b. City,	Town, or	Location of	of Death		4c.	County	of Death		
			Laurel Regional Ho				Laure					F	rince	Geo	rges	
	Funeral		5. Social Security Number	6. Sex 1 M 2 □ F		yrs. last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, D	irth 'a <i>y, Year)</i>		9. Birth	olace (State ntry)	or Foreign
	Director		217-28-8144 Usual Residence of Decedent	10		76 Yrs.					April 1	5, 192	29	Mary	land	
	land		10a. State 10b. County	/	10c.	. City, Town or Lo	cation								I 0d. Inside	City Limits
	Mary	ō	Maryland Prince	Georges	د ا	urel									1 🙀 Ye	s 2 No
	ith the Marylar or 28a-1 show w nutition at	Director	10e. Street and Number	- GCO1 900	La	4101	10f. Zip	Code				10a. Cit	zen of W	hat Cou	ntry?	
	within 72 hours after deeth with the Maryland one. than "natural", or items 23s or 28s-1 show ite Medical Exarting ressibe rutilied at	<u>=</u>	914 Phillip Powers	Drive			2070	7								
	items 2	by Funeral	11. Marital Status	12. Was Dec	edent Ever i	n U.S. 13.			spanic Ori	gin? (Spe	ecify Yes or N Rican, etc.)	Unite	Race	- Ameri	America can Indian,	
9	or ite	Ē	1 ☐ Never Married 2 ☒ Mar		2 🔣 No	1					Rican, etc.)			, White,		
5-0036	ral',	t by	3 ☐ Widowed 4 ☐ Divorce	d If Yes, G Year or I	Dates:		1 □ Yes	DO NO	Specify:				Specify:	₩h:	ite	
5-0	72 h	Completed		nt's Education est grade completed)	16a. Dece	kind of wo	rk done d	lurina mosi	t of work	ina	16b. K	nd of Bus	iness/Ir	dustry	
2121	ithin of the	du	Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT us	se retired,)		9					
2	led w lygier her ti		11	1 2		Salesma	ın						Retai			
and	be fi	Be	17. Father's Name (First, Middle,	, Last)							e (First, Middle	a, Maiden	Sumame)		
7	d Mer narke	To	Bernard Kilby							ice Ut						
Maryland	s 1 and 2 should be filed within 72 hours if Health and Mental Hygiene. Item 27 is marked other than "natural; other traumatic event, the Mudical Exe		19a. Informant's Name/Relation:								al Route Numi	oer, City o	r Town, S	State, Zip	Code)	
_	1 and 1ealth 9m 27 ther to		Harriett Kilby/Wif	e	20	914 Ph			s Driv		Laurel Date	Mary1		2070	-	
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ţi	t. Partmen	Harriett Kilby/Wife 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Pother (Specify) 21. Signature of Function Service Licensee 22. Name and Add Fleck Function For Standard Standa								1/17/	2006	Bren	twood	, Mar	yland	
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	402 40) win	Z WI	nu ·	76	01 San	dy Sp	ring R	Road	Laurel	Mary	land	2070		
ą.			23a. Part1. Enter the disease, o shock, or heart failure. Lis	t only one cause on	each line.	eatri. Do not ent	er the mod	e or ayıng	g, such as	cardiac o	or respiratory i	arrest,			Approximation Interval Be Onset and	etween
	Physician		Immediate Cause (Final disease or condition resulting in death)	Cardi	ac Arres	st									Minute	
	/Medical Examiner		, and a second			sequence of): atory Fail	uno									
		la di	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b		sequence of):	ure									
	ted nslt	nln e	Cause (Disease or injury	₹ 5.50 %	(0) 43 4 0011	soquerice (ii).										
_6	death certificate be executed e ettending physicien and od for use as the burial-transit	Examiner	that initiated events resulting in death) Last	c	(or as a con:	sequence of):										
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	death certifica ettending ph d for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, or	itcome of pre								23d. Date	of delive	nn/	
Вох	etter for	clar	in the past 12 months?		birth 2 □ F nant at time (]Ectopic pr] Other <i>(sp</i>						Mon		Day	Year
o.	that the de ed by the detached	lys	9 Unknown	9□ Unki	nown											
۵	that	by Pł	Part II. Other significant conditi	ons contributing to	death but not	resulting in the u	nderlying c	ause give	n in Part I.		23e. Did	tobacco u	se contril	oute to th	ne cause of	death?
rds,	n sign	D D	Congestive Heart F	ailure							1 🗆	Yes 2	□No :	B 🗆 Prob	ably 4 5	Unknown
Record	w requir s been s should	lete	Rheumatic Heart Di	sease							24a. Was	an	24b. W	ere auto	psy finding:	s available
Re	The law requires that the sate has been signed by the page 2 should be detache	Completed	Chronic Obstructiv	a Luna Diasa								ormed?	pr	ior to co ath?	npletion of	cause of
Vital		a l	25. Was case referred to medica		ise				26 Place	of Dogsth	1 ☐ Yes	^	11	∃Yes	2□ No	
>		To B	examiner? 1 ☐ Yes 2 ☐ No	Lionnital	Inpatient 2	2 ☐ ER/Outpatien	t 3 🗆 DO	A Othe	_		me 5□Res		: □Othor	(Sancif	.1	
of			27. Manner of Death	28a. Date	of Injury	28b. Time of		8c. Injury Work			28d. Describe				')	
Division	Attending F ir death. ector: After by the funera	Certification:	1 ☐Natural 5 ☐ Pendi 2 ☐ Accident invest	ng (MOI igation	nth, Day Year	r) Injury	М		? ′es 2 🗀 l	No						
vis		il l	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be 28e. Plac	e of Injury - A	At home, farm, str ecify)	eet, factory	, office		1	28f. Location	Street an	d Number	or Aura	l Route Nu	m <i>ber</i> ,
Ö	al or A s after ii Direct od in by	Cert	4 - Homicide	Bulk	nng, etc. (<i>Sp</i> e	өспу)					City or To	wn, State)			
	pspit hour unera ly fills		29a. Certifier 1 € Certifyi (Check only 2 ☐ Medical	ng Physician: To th	e best of my	knowledge, death	occurred	at the time	e, date and	d place, a	and due to the	cause(s)	and man	ner as s	ated.	
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	one)	Examiner: On the I	ner stated.	nination and/or in	estigation,	in my op	inion, deat	th occurre	ed at the time,	date and	place, ar	nd due to	the cause	(s)
	To the Hospital within 24 hours a To the Funeral I completely filled	Σ	29b. Signature and title of certific		12	0 11	290	. License	number	. ~		29d. Dat	e signed	(Month,	Day, Year)	
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1	?		30. Name and address of person						- 0		y		- 1		,	
1) .		William A. Warren,	MD 321	Prince	Georges S	Street	Lau	rel	Maryl	land 2	0707				
	Sta		31. Date filed (Month, Day, Year,	32, 1	Registrar's Si	gnature		-								
	Registi	ar	JAN 1 9	2006	80684	E ALLE	5000									

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. U 6 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) 6:20 PM Year KLEIN, Jr ALLEN TANCEARY 2006 4 ALLCIV a Fecility Neme (If not institution, give street end number) HAMILTON GENESUS CENTER, GOLD HARFOLD BACTIM RE N/A HAMILTON GENESUS (ENTER), GOLD HARFOLD BACTIM RE N/A 11 Under 1-Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) (Month, Dey, Year) (Month, Dey, Year) (November 11, 1930) November 11, 1930 Mary Land 4a Fecility Neme (If not institution, give street end number) 5. Social Security Number Usual Residence of Decedent 10d. Inside City Limits 10a. Stete 10b. Count 10c. City, Town or Locetion 1 Yes 2 No Baltimore Maryland N/A 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 6605 Walther Avenue Apt TA 21206 LISA 12. Was Decedent Ever in U,S. Armed Forces? ₩XXYes 2 □ No KOYea If Yes, Give Year or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. XX Never Married 2 Married 1 ☐ Yes 2 XXNo Specify. White Specify. 3 Widowed 4 Divorced 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondary (0-12) Benefits Clerk State of Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Hilda Boss Allen Lorraine Klein Sr 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10105 Tipperary Road Baltimore, Maryland 21234 Elaine K McLean Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1AABurial 2 ☐ Cremation 3 ☐ Removal from State 1/20/06 Druid Ridge Cemetery Pikesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility Mitchell-Wiedefeld Funeral Home Inc 21. Sonature of Funeral Service Ligensee nakes 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) METASTASIS CANCER IN BRAIN AND Due to (or es e consequence of): LUNG CANC NON SMALL COLL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of) Due to (or as e consequence of): CCHRONIC OBSTRUCTIVA PULMONARY DISEMS=) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? HYPERTENSION PROSTATIC HYPERTREPHY BENIGIS 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Universing Home 5 Residence 6 Other (Specify) 28c. Injury et Work? 28d. Describe how injury occurred 1 Yes 2 No

Physician /Medical Examiner

Examiner

Physician/Medical

Be Completed by

Certification: To

edicai

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural" or Hamman any linury or other traumatic event.

that the death certificate be axecuted P.O. Box 68760, ds, this certificata has The

attending physician and I for usa as the burial-transit ed by the a director. To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral d

Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. COMONARY ARTERY DISCHIB 25. Was case referred to medical examiner? 1 Yes 2 No 27. Menner of Death 1 Naturel 5 Pending investigation 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 ☐ Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) end menner steted. 29a. Certifier

29b. Signature end title of certified

DR MAW N.00, ND 00062237.

29c. License number

29d. Date signed (Month, Dev. Year)

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) DR MAU NACN Q 00, MD

GEN 2515 CENTER, GOYO, HARRORD RD, BATIMORD

JANUARY 18 2006

HAMILTON 31. Dete filed (Month, Day, Year)

(Check only one)

32. Registrer's Signeture

State Registrar JAN 1 9 2006



DHMH 16 Rev 6/95

			1 - For State Registrar	State of Maryland /	-	artment <i>tificate</i>			and Me		jiene	2006	009	88
>	Physici		1. Decedent's Name (First, Middle, Last)	ne G. Knecht						Month	Day	Year 200	3. Time of De	
	/Medic Examir		4a. Facility Name (If not institution, give					Location o	f Death		-	County of Dea	ith	
*	Funeral Director		5. Social Security Number 320-10-8020 Usual Residence of Decedent	7. Age (In yrs. last)	birthday) Yrs.	If Under Months	Year Days	If Under 2 Hours	Min.	B. Date of Birth (Month, Day, EB 22,	Year) 191	9. Bi	thplace (State or F ountry) linois	oreign
	72 hours after death with the Maryland natural', or iteme 23a or 28a-f ehow disal Exantiner must be notified at	Direc	10a. State 10b. County Maryland Baltimo 10e. Street and Number	own or Lo		Code	onsvi	lle	1	l0g. Citize	10d. Inside City Limits 1 □ Yes 2X; No g. Citizen of What Country?			
5-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. Item 27 Ie marked other then "natural", or iteme 23a or 28a-f show other traumatic event, Ire Medical Examinar must be notified at	d by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Amed Forces? 1 XYes 2 No If Yes, Give Year or Dates: 1942-45	5	1□Yes 2	ent of His fy Cubar	Specify:	gin? (Spec i, Puerto R	ify Yes or No- ican, etc.)	5	USA 4. Race - Am Black, Whi	White	
21215-	within 72 tene. then "nate	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation 16 e completed) College (1-4or 5+)	(Give life. L	dent's Usual kind of wor DO NOT usi giste	done d retired,	luring most)		9		d of Business ealthca		
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altimore, Mary	o O		19a. Informant's Name/Relationship (Ty Linda K. Wayland) 20a. Method of Disposition 1□Burial 2 (XCremation 3□R	Dau hter emoval from State	719 N of Dispo	Maider sition (Nam natory or oti	n Che e of her place	oice	r or Rural Lane, Da	Route Number HR546 te	cat Cat 20c. Loc	Town, State, Onsvil ation - City or	1c, MD 2 Town, State	1228
Baltin	permit. Page Department fmportant: If eny injury o once.		4 □Donation 5 □Other (Specify) 21. Signator o Funeral Service Licens Edward A Gree	Metro S. S.C. Orchik	22	. Name and	Addres	s of Facilit	y Cre		Soci	iety o	re, MD f MD, Inc 228	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complished, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentiafly list conditions	METABOLI Due to (or as a consequence MOSA SE	c of):	myc			cardiac or	respiratory arr	est,		Approximate Interval Betwee Onset and Dec & L DA	ath YS
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury trainitated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):											2307	ES CONTRACTOR
O. Box 6	that the death certifica ed by the attending pl detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 9 □ Unknown	oregnancy pecify)					23d. Date of defivery Month Day Y				
Records, P.	w requires that been signed b should be deta	þ	Part II. Other significant conditions con	ntributing to death but not resulting	g in the ur	nderlying ca	use give	n in Part I.	_	23e. Did tol			o the cause of dea	
al Rec	The ete h page	e Completed	25. Was case referred to medical						_		med? 200 No	24b. Were a prior to death?	utopsy findings ava completion of caus s 2 No	allable se of
of Vital	Physician: this certificant al director, i	To Be	examiner?	lospital: 1 patient 2 ER/	Outpatien	ıt 3□ DO.	Othe	V-		Check only on e 5 ☐ Reside		☐Other (Spe	ecify)	
Division of	Attending in death. ector: After by the fune	Certification: 7	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 2 Natural 5 Pending investigation 6 Could not be determined	28a. Place of Injury (Month, Day Year) 28e. Place of Injury - At home, building, etc. (Specify)	o. Time of Injury	М		at ? (es 2 🗆 I	No	Bf. Location (St City or Town	treet and		ural Route Numbe	r,
Ω	To the Hospital or within 24 hours effer to the Funeral Dir completely filled in	edical Cer	29a. Certifier (Check only one) Certifying Physical Examination	sician: To the best of my knowled nar: On the basis of examination and manner stated.	dge, death and/or inv	n occurred a vestigation,	t the tim	e, date an	d place, ar	nd due to the ca	ause(s) a late and p	and manner a	s stated. e to the cause(s)	
•	To th within To th compl	Me	29b. Signature and title of certifier	frese my)-··	6	00			5 J	Arey	(A24	th, Day, Year)	4
	St	ate	30. Name and address of person who co K/1+/2-L V (C - 1) 31. Date filed (Month, Dat Mar) 1 9	mpleted cause of death (Item 23: +EIZSOH M.C. S	100	Print) C(A	701	4 A	V 804	LE, BA	ITI	MOVLE	MUZIZ	25

LAUSCHE KMECIT

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Day Year Physician KOHLER Louis G ANUARY 1915 /Medical 16 2006 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner RANDALLSTOWN NORTHWEST HOSPITAL BALTIMORE If Under 24 Hrs. 8. Date of Birth Hours MinOctober 13,1928 9. Birthplece (State or Fore Pennsylvania 7. Age (In yrs. last birthday)
77 Yrs If Under 1 Yeer 5. Sociel Security Number 6. Sex 9. Birthplece (State or Foreign **Funeral** Days Months **X**☐ M 2□ F Director 213-24-6841 Usual Residence of Decedent death with the Maryland 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23s or 28s-f show other traumatic event, the Madical Examiner must be notified at Baltimore 1 ☐ Yes 2 🙀 No Maryland Randallstown Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 10003 Oak Glen Road Funerai United States of America 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status ified within 72 hours efter de Hygiene. Hygiene. other than "naturei", or item 1 ☐ Yes 2**X** No If Yes, Give 1 Never Merried 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: þ Specify: 3 Widowed 4 □ Divorced White Year or Dates: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) EMD Industrial 12 0 Branch Manager Pages 1 end 2 should be filed vent of Heelth end Mentel Hygie ant: If Item 27 is marked other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) å Louis George Kohler Elizabeth K. Echelmeyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis G. Kohler III (Son) 10003 Oak Glen Road, Randallstown, Maryland 21133 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ò 4 ☐ Donation 5 ☐ Other (Specify) 01/20/06 Sykesville, Maryland Lake View Memorial Park 22. Name and Address, of Facility Loring Byers Funeral Directors, Inc. 21. Signature of Furieral Service Licensee 8728 Liberty Road, Randallstown, Maryland 21133 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical hours Examiner Due to (or as a consequence of): Examine requires that the death certificete be executed nding physician end use es the buriel-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of): attending for use es Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown by 2 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificete hes 1 ☐ Yes 2 XNo 1 ☐ Yes 2 No Be 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 12 Inpatient 2 ER/Outpatient 3 DOA 2 1 Yes 2 No To the Hospital or Attending Physiwithin 24 hours after death.

To the Funersi Director: After this completely filled in by the funerel dir After this 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Tyes 2 No 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier De Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as steted.

| Medicat Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. Medicai 29b. Signeture and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) D0059736 14, 2006 rather mo 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) LOURT ROAD WORTH WEST WATSON mo OLD DEBURAH MOSFITAL 5401 32. Registrer's Signature 31. Dete filed (Month, Day, Ye State 0816 Registrar

DHMH 16 Rev 6/95

ORIGINAL

		For State Registrar	State of	Maryland			of Health of Death		ental Hygier	7000	00990
ELWIE	· ·	Decedent's Name (First, Middle,	Last)		-				2. Date of Death Month	Day Year	3. Time of Death
Physic /Medi		Iris Opa	l Lai:	rd						14, 2006	5:40 P M
Exami		4a. Facility Name (If not institution,	give street and num	ber)		4b. City, To	own, or Location	of Death		4c. County of Deat	1
		Gilchrist Cent					OWSON Year If Under	e 24 Mrs	0.5. (5:0	Baltimor	
Funeral			5. Sex 1 ☐ M 2 💢 F	7. Age (In yrs. Ia	ast birthday) Yrs.		Days Hours	Min.	8. Date of Birth (Month, Day, Yea	9. Birti Co	nplace (State or Foreign untry)
Director		Usual Residence of Decedent		78					Sept 2, 1	1927 Nor	th Carolina
yland		10a. State 10b. County		10c. City	, Town or Lo	ocation					10d. Inside City Limits
Mar B-f-et	ctor	Maryland n/a			Balti	more					1∭ Yes 2 No
ith the Marylar or 28a-f ehow	Director	10e. Street and Number				10f. Zip C	ode		10g. (Citizen of What Co	untry?
ath w		6113 Marlora Ro					21239			USA	
er de	Funerai	11. Marital Status 1 □ Never Married 2 X Marrie	Armed For		5. 13.	Was Deceder If Yes, specify	nt of Hispanic Or y Cuban, Mexica	rigin? (Spec an, Puerto P	lican, etc.)	14. Race - Ame Black, White	
Ir, or	byF	3 □ Widowed 4 □ Divorced	If Yes, Give	9		1 ☐ Yes 2 ፟	No Specify	<i>'</i> :		Specify: Wh	ite
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gient genth	Con	12	5+			Teach				Educati	on
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should be nd Mentel marked c	2	Ira Elbei		Shumate	405 14 11	- Add (In			kie	Hurley
2 2 2 2 3		19a. Informant's Name/Relationshi		1					Route Number, City		
s 1 and 3 f Heelth item 27 other tr		Dr. Donald F. I	Laird/Hust	20b. Pla	ace of Dispo	sition (Name	of	Da	ltimore,	Mary Land Location - City or	
Pages nent of i		1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		itate		matory`or othi	•		0, 2006 T	imonium	Maruland
permit. Pages Depriment of the Important: If its any injury or of one.		21. Signature of Fune/al-Service V	00	2) L	1922	Name and	Mem. Ga Address of Facil	lity			Maryland
Den den den den den den den den den den d		Bryan W. CI	$\mathcal{U} \cup \mathcal{U}$	e y	L	emmon	Funeral	Home	of Dulan Timonium	ey Valle	y Inc.
		23a. Part 1. 5 ter the disease, or c shock or heart failure. List o	omplications that ca	used the death.						19 1110 21	Approximate Interval Between
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eath eath	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🔀 No	1 ☐ Live bir	rth 2 ☐ Fetal ant at time of de	death 3□	Ectopic preg Other (spec				Month	Day Year
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that so that hed be determined by	by Pt	Part II. Other significant condition	s contributing to de	ath but not resu	lting in the u	nderlying cau	ise given in Part	I.	23e. Did tobacc	o use contribute to	the cause of death?
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ysic hysic nis ce	10	1 Yes 2 No		·	ER/Outpatier	nt 3 DOA	Other: 4 N	lursing Hom	e 5 🗆 Residence	6 Other (Spec	HOSPICE
ng Phy Mter thi		27. Manner of Death 1 DNatural 5 □ Pending	28a. Date of (Month	f Injury n, Day Year)	28b. Time of Injury		. Injury at Work?		8d. Describe how in	jury occurred	
VISION Attending or death. ector: Afte by the fune	cati	2 Accident investiga 3 Suicide 6 Could no	ation			М	1 Yes 2				
or Att	Certification:	4 Homicide determin	286. Place	of Injury - At hor g, etc. (Specify)		eet, factory, o	office	2	8f. Location (Street City or Town, Sta	and Number or Ru ate)	ral Houte Number,
pitel ours e		29a. Certifier 1 Certifying	Physician: To the	hast of my know	uladaa daatt	h accurred at	the time date of	nd place or	ad due to the serve	(a) and manner as	atatad
Hos 24 ho Fun stely f	edicai	(Check only 2 Medical E	xaminer: On the ba	sis of examinati	ion and/or in	vestigation, in	n my opinion, de	ath occurre	d at the time, date a	ind place, and due	to the cause(s)
To the Hospitel or Attending Physicien: The law within 24 hours effer death. To the Funeral Director: Affer this certificate has completely filled in by the funeral director, page 2	Me	29b. Signature and title of certifier	_			29c. l	License number		29d. [Date signed (Month	, Day, Year)
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		LI DMIXIS		21000	11		0256	04-	5	11010) 006
17		30. Name and address of person w	tho completed cause	of death (Item			0256	04-2	10	/15/0	9006
1/2		30. Name and address of person w	iulleners	ND/6	601 N	Print) J. Cha	D256 iules S	steet	-/Bult	o MD a	1204
St Regist	ate	30. Name and address of person when the state of the stat	iulleners		601 N		D256 Wes S	steat	/Bult	OMD 3	1204

Janvary 14, Loto >- top

physician and s the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, attending pl signed by the a Id be detached for been si should certificate has t irector, page 2 s or Attending Physician: director, this After thi death.

To the Hospital

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rag. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Rec 0428 AM a 200G /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Medical ALtimoRe SALtimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1X M 2□ F 74 Yrs December 16 1931 VIRGINIA Director 227-32-9146 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 77 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 🖾 No Director ABERDEEN MARYLAND HARFORD CO 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 668 ELM STREET 21001 U.S.A. Funeral filed withIn 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1XXYes 2 □ No If Yes, Give Year or Dates: 65/70 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married XXMarried ltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: BLACK Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSING HOUSING INSPECTOR 12th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental ဥ BESSIE ANN MAYO HARRIS unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 i 668 Elm Street, Aberdeen, Md., 21001 Naomi Mayo/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ē **! .** 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Importent: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) ST JAMES CEMETERY 01-17-06 HAVRE DE GRACE, MD. 21. Signature of Funeral Service Lice; 22. Name and Address of Facility UNITY FUNERAL HOME-HARFORD, P.A. 321 S PHILADELPHIA BLVD, ABERDEEN, MD 21001 Much Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Bleed **Physician** Day disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Gastric -Mwbhamc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events Due to (or as a consequence of): Examiner resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 ☐ Ectopic pregnancy Month Dav Year in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred 27. Manner of Death Injury at Work? Certification: 1 Natural Injury 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifiei 1[Y Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M LQ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IMO 2 vicale 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 1 9 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				State of Maryland / De	epartment of Health and I	•	_							
				1 - State Registrar	Certificate of Death	Reg.	2006 00992							
	200	Physici		Decedent's Name (First, Middle, Last) MINNIE PEARL McCOY		2. Date of Death Month	Day Year 3. Time of Death							
	185	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	n	4c. County of Death							
		auiiii		UPPER CHESAPEAKE HOSPITAL	BELAIR		HARFORD CO							
		Funeral Director		5. Social Security Number 423-72-5868 6. Sex 1 M XXF 7. Age (In yrs. last birtho	Months Davs Hours Min.	8. Date of Birth (Month, Day, Ye JUN 6 19								
	7	g * :		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of	or Location		10d. Inside City Limits							
	Share A	De liled within 72 nouts after death with the Maryland Nat Hygiene. Ad other than "natural", or teme 23a or 28a-1 ehow event, the Machcal Examinar must be notified at	tor		GEWOOD		1 ☐ Yes 2 🛛 No							
	t d	or 284	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?							
	45	am w 9 23a	rai	802 SAILBOAT COURT	21040		U.S.A.							
	ò	or Iteme	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ★ Married 1 □ Yes 2 ★ No	 Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puerl 	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.							
	21215-0036	ral', or	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 【 No Specify:		Specify: BLACK							
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5	bu	tal Hygid d other event,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Nam	ne (First, Middle, Maid	den Sumame)							
	ylaı	should be nd Menti s marked umatic e	To	LIM WALLACE KING		EL CARTER								
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7	altimore,	. 든 든 중 .		21. Signature of Funda Sorvige Control			·							
-	m	Depa impo eny ii		Desum	321 S PHILADELPHIA	A BLVD., A	L HOME-HARFORD, P.A. BERDEEN MD 21001							
		Physician /Medical Examiner		23a. Part 1. Effect field disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Small cell lun		Onset and Death							
tesbe	8760,	ures that the death certificate be executed signed by the attending physicien and die detached for use as the burial-transit	dicai Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): d.										
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116	ds, P	requires that the een signed by th hould be detache	Ď	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.		co use contribute to the cause of death?							
oy, Minnie	Recol	as b	Completed			24a. Was an autopsy performed								
	ita	ortifica ctor, 6	Bec	25. Was case referred to medical examiner?	26. Place of Dea	ath Check only one								
5	2	this ce al dire	ို	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa			e 6 ☐Other (Specify)							
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0	Division	or Attending after death. Director: Afte I in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined determined 28e. Place of Injury - At home, farm building, etc. (Specify)		28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)							
E		To the Mospital or Atending Prysician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, decided Examination and/control and manner stated.	leath occurred at the time, date and place or investigation, in my opinion, death occu	, and due to the cause irred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)							
	-	o the o the o mple	Me	30h Sinnatura and titlem certifier	29c. License number	29d.	Date signed (Month, Day, Year)							
) '	- > - 0		& Seinsalam N	1.D D45530	Oi	1-17-2006							
	•	1		30. Name and address of person who completed cause of death (Item 23a) (Ty S . SIU A SAI LAM , SLUTE 20 S	s atwood roal	s, Beia	LET MD 21 OIL							
	(1)	Sta Registi		31. Date filed (Month, Day, Year) JAN 1 9 2006 32. Registrar's Signature	parte									

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

06-00323 WILLIAM E.McDANIEL Amend Unpend item #1,23a,27,28a-f, penME,0852,2/16/06 The Amend Unpend Item #1,23a,27,28a-f, penME,0852,2/16/06 The Amend Unpend Item #1,23a,27,28a-f, penME,0852,2/16/06 The Amend Unpend Item #1,23a,27,28a-f, penME,0852,2/16/06 The Amend Unpend Item #1,23a,27,28a-f, penME,0852,2/16/06 The Amend Unpend Item #1,23a,27,28a-f, penME,0852,2/16/06 The Amend Unpend Item #1,23a,27,28a-f, penME,0852,2/16/06 The Amend Unpend Item #1,23a,27,28a-f, penME,0852,2/16/06 The Amend Unpend Item #1,23a,27,28a-f, penME,0852,28a-f, penME,0852,28a-f, penME,0852,28a-f, penME,0852,28a-f, penME,0852,28a-f, penME,0852,28a-f, penME,0852,28a-f, penME,0852,28a-f, penME,0852,28a-f, penME,0852,28a-f, penME,0852,28a-f, penME,0852,28a-f, penME,0852,28a-f, penME,0852,28a-f, B.K.S UNKKNOWN 1 - For State Registrar Reg. No. UU6 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** William Everette McDaniel, Jr. 13, JAN. 2006 0955 /Medical 4b. City Iown or Location of Death BALTIMORE CITY 4c. County of Death 4a. Facility Name (Most institution, give street and number) 226 SOUTH FULTON AVENUE Examiner | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 7-26-1961 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Maryland 1(3tM 2∏ F 218-62-9614 44 Yrs. Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23a or 28a-f ehow the Medical Examiner must be notified at 1 √ Yes 2 No Baltimore MD N/ADirect 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 21223 U.S.A. 208 S. Payson Street death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 is marked other than "naturel; or ite 1 ☐ Yes 2 ◯XNo If Yes, Give Year or Dates: Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Glass Cutter 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ina Ruth Odom William Everette McDaniel, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6664 Shelly Rd. Apt 36 Glen Burnie, MD 21061 Ina Ruth Moses/Mother 20b. Place of Disposition (Name of cometery, crematory or other place)
Loudon Park Cemetery Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite eny injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State 1-17-2006 Baltimore, MD 4/⊟Donation 5 ☐ Other (Specify) 21. Son lure of Funeral Service Licenses Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD 21227 23a. Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Narcotic (Heroin) Intoxication /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury Qualto (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed that initiated events attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year Month 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 1e in?

1 X es 2□ No 24a. Was an autopsy 1 Yes 2□ No Be 25. Was case referred to medical 26. Place of Death | Check only one examiner?
1 2 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence Worther (Specify) AT SCENE ၉ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Fnd After Injury 1 Natural 5 Pending М 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. investigation 9:30 A 2 Accident 1/13/2006 6 X Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 226 South Fulton St. Baltimore City, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Found: in vacant house Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) the e 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E 14, 2006 JAN. death (Item 23a) (Type, Print)
111 PENN STREET, BALTIMORE, MARYLAND 21201 30. Name and address of person who completed car -7

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

2. Registrar's Signature

			For State		State of	of Mary	land / Dep		nt of He te of D			ental Hy	9	006	00995	
			Registrar 1. Decedent's Name (First, Mid	dle, Last)		_		71 timou	0 01 2	Out		2. Date of De		000	3. Time of Death	
	Physicia /Medic	-	SAMES						MALON	1E	;	Month SANUAR	Day	Year 200	. 10. 44	
*	Examin		4a. Facility Name (If not institut	on, give s	treet and nu	umber)		4b. City	4b. City, Town, or Location of Death					4c. County of Death		
			JOHNS HOP			PITAL	and the state of		TIMORE or 1 Year		ler 24 Hrs/	0.0		NA		
	Funeral		5. Social Security Number 120–38–8114	6. Sex	M 2□ F		n yrs. last birthdaj 56 Yrs.	Months		Hours		8. Date of Bir (Month, Da	77. Year)	9. B	rthplace (State or Foreign ountry) N.Y.	
*			Usual Residence of Decedent			•	JO					3-2	.7-43			
	ryland how		10a. State 10b. Coun	ty		10	c. City, Town or	AFIVE OF A								
	Ba-f e	Director	Md.	NA			Ba	ltimo							1X Yes 2 No	
	with the	Dire	10e. Street and Number 26 N. Spring Street							221			10g. Citizen of What Country?			
	9ath 1	Funeral	11. Marital Status		eet 12. Was Dec	cedent Eve	r in U.S. 13	21231 USA 3. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.							eńcan Indian.	
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	permit. I Departm Importa eny inju		21. Signature of Funeral Service		3/				and Address	of Fac	cility	Balt		e, Md.	21202	
ä	P C L C C C C C C C C C C C C C C C C C		Junt	TA	9			March	F.H.	Eas	st	1101	E. No	orth Av		
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,	cate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	C	Due to	o (or as a co	onsequence of):									
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0	ntifica ng ph s as th	0	IF FEMALE:													
ŏ n	death certificate be executed e attending physician and nd for use as the burral-transit	Physiclan/M	23b. Was decedent pregnant in the past 12 months?	2:		birth 2	Fetal death 3	Ectopic					2	3d. Date of de Month	elivery Day Year	
- -	ne de the a	ysic	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	Ė	4∐Preg 9□ Unki	nant at tim nown	e of death 5	□ Other (іресіту)							
7.	requires that the de een signed by the a hould be detached f		Part II. Dther significant cond	itions con	tributing to	death but n	ot resulting in the	underlying	cause give	n in Pa	ırt I.	23e. Did	tobacco us	se contribute t	to the cause of death?	
SD.	w requires that been signed t should be det	d by										1 🗆	Yes 2]No 3□P	Probably 4 Unknown	
Hecords		Completed										24a. Was		24b. Were a	utopsy findings available	
	The ta	mo										auto perfe	psy ormed? 2 \Bo	death?		
Vital		Be C	25. Was case referred to med	cal						26. Pla	ace of Death	(Check only				
01 <	<u>≻</u> .s p	To	examiner? 1 Tes 2 No	Н	lospital:	Unpatient	2 ER/Outpati	ent 3 🗆 🛭		4 🗆			_	☐Other (Spe	ecify)	
	ng fter Inei		27. Manner of Death 1 ∠Natural 5 □ Pen	ding		e of Injury onth, Day Yo	ear) 28b. Time	/	28c. Injury Work		1	8d. Describe	how injury	occurred		
<u> </u>	Attending For death. ector: After by the funera	catl	3 Suicide 6 Cou	stigation		6 talum	A4 hama 42	M		es 2		19f Location	'Street and	(Number or E	Rural Route Number,	
DIVISION	or At after c Direc in by	Certification:	4 Homicide dete	mined	28e. Plac	ding, etc. (- At home, farm, : Specify)	street, racto	гу, опісе				wn, State)	i Number or F	nurai noute Number,	
_	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical Co	29a. Certifier Certif	ying Phys al Examir	ner: On the	ne best of m basis of ex	ny knowledge, de amination and/or	ath occurre investigation	d at the time in, in my opi	e, date inion, d	and place, a death occurre	nd due to the	cause(s) a	and manner a place, and du	us stated. te to the cause(s)	
	o the vithin o the	Me	29b. Signature and title of cert	fier				2	9c. License	numbe	ər		29d. Date	signed (Mon	nth, Day, Year)	
	C>F0		> 5-		5	CHENO	1, MD		res	-00	0		IMI	AMY 1	4,2006	
	M		30. Name and address of pers	on who co				e, Print)								
	")		susan cheng	Th	-		PKINS HO			00 1	JORTH W	OLFE ST	neet	BALTIN	NORE, MANYLAWD	
	Sta		31. Date filed (Month, Day, Ye		32.	Begistrar's	Signature	Corelle	,							
	Registr	ar	JAN 1	9 200	16	1098	A P									

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			For Stete Registrar		State of N	Marylan		artmen rtificat					Reg. No.		5 (009	96
	Physici	an	Decedent's Name (Fire		t)							2. Date of Dea	Day		ear_	3. Time of	
	/Medi		James D. 1							. 154		Januar	4	1, 200		3:25	P ^M
	Examir	ner	4a. Facility Name (If not i	-			nton		_	Location o	of Death			County of 0			
			Southern I				last birthday)	If Under	into	II If Under	24 Hrs.	8. Date of Birt		rince		-	Fomian
	Funeral Director		249-13-5432	. 7	X M 2□F	46	Yrs.	Months		Hours	Min.	(Month, Da Mar. 12	y, Year)	959	Country	ce (State or v) n Caro	olina
			Usual Residence of Dece			40						riat. 12	s, 13	333 3	JOULI	1 Care)TIIIa
	yland Now		10a. State 10b	. County	* " -	10c. Cit	y, Town or Lo	cation					,		100	l. Inside Cit	y Limits
	Mar Mar	tor	MD C	harles		Wa.	ldorf									1 🗌 Yes	2 X No
	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hydene. I Health and Mental Hydene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, Ite Madical Examiner must be notified at	Funeral Director	10e. Street and Number	ntru In	20			10f. Zip	Code				10g. Cíti	zen of Wha	t Countr	y?	
	th wi	al	12727 Cou	псту га					2060					J.S.			
	ems ems	Iner	11. Marital Status		12. Was Decede Armed Force	s?	.S. 13.	Was Deced If Yes, spec	dent of Hi city Cuba	ispanic Ori n, Mexicar	igin? (Spe n, Puerto l	cify Yes or No Rican, etc.)	-	14. Race - A Black, V	American White, et		
36	or it	γFι	1 Never Married		1 ☐ Yes 2 I If Yes, Give	_		1 ☐ Yes	2 <mark>⊠</mark> No	Specify:				Specify:	Blac	:k	
21215-0036	hours turali	Completed by	3 Widowed 4 1		Year or Date	s:	16a. Dece	dent's Heur	al Occup	ation				nd of Busin			
5	n 72	lete	(Specify or	Decedent's Edi	de completed)		(Give	kind of wa DO NOT u	rk done c	lurina mos	t of worki	ng	IOD. Ki	nd di Busin	922/11/00	suy	
12	within ene. than	E C	Elementary/Secondary	y (0-12)	College (1-4d	or 5+)		iness					Ce	eneral	Cor	n+ract	-ina
	filed Hygi other	0	17. Father's Name (First,	, Middle, Last)			Dus.	LIICOO	OWII		er's Name	(First, Middle,				ILLACI	-1119
lan	ld be ental ked c	ToB	James Ma	con						Jen	nie	Johnson					
Maryland	2 should be filed within and Mental Hyglene. is marked other than aumatic event, It e Max	-	19a. Informant's Name/F	Relationship (T	ype, Print)		19b. Maili	ng Address	(Street a	1508		l Route Numbe		r Town, Sta	te, Zip C	ode)	
S	and 2 salth a n 27 is		Yvette Pun	ch (wif	e)		1272	7 Cou	ntry	Lane	e, Wa	ldorf,	MD 2	20601			
Ē,	s 1 and s 1 Health item 27 other tr	1.3	20a. Method of Disposition			1 ~	Place of Dispo	sition (Nar	me of other plac	a) 1	D	ate	20c. Lo	cation - City	y or Tow	n, State	
OE.	Pages nent of int: if it		1 🖾 Burial 2 🗍 Cre 1 4 ☐ Donation 5 ☐			te i		-			1/17	/2006	Fair	fax C	·.o.	VA	
Baltimore	그 든 환경		21. Signature of Funeral							s of Facilit		wis Fun				***	
ä	Depa Depa impo any ir		Hidiy	145	WINS	ON	3.	LI N.	Pat	rick		Alexan				4	
8760,	Physician Independent Independ	al Examiner	23a Parl 1. Enter the dis shock, or heart failt immediate Cause (Final dis se or condition resulting in death) Sequentially list condition if any, leading to immediate the cause (Disease or injury that initiated events resulting in death) Last	ſ	a. Athe Due to (or b. Due to (or c.		erotic uence of): uence of):									nterval Betwonset and C	
P.O. Box 687	the death certific by the attending parched for use as	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregin the past 12 mont 1 Yes 2 No 9 Unknown	ths?	d	2 ☐ Feta t at time of d	Ideath 3[eath 5[Ectopic p	pecify)	an in Part I		23e. Did to		23d. Date of Month	Ď	ay Y	ear
Records,	98	d by	Tall II. Other Significant		minouning to double	1 501 1101 100	anny in the a	ndonying c	auso givi	J11 111 1 WILL	•		/es 2[Probab		nknown
OC	> 0 %	Completed			-							24a. Was	an	24h Wer	e autons	y findings a	ıvailahle
Rec	The law ite has b	m										autop		prior	r to comp th?	detion of ca	use of
_ _	n: The ficate r. pa		25. Was case referred to	- madical								23	2□ No	1 X	Yes 2	□ No	
Vital	Physician: this certific ral director,	o Be	examiner?		Hospital: 1 ☐ Inpa	ntions 2 M	ER/Outpatier	. a[] [0(Othe	000		(Check only o		C COther (Cassiful		
of	Phys r this ral d		27. Manner of Death		28a, Date of I	njury	28b. Time o		28c. Injury World	4 🗆 140		28d. Describe h			<i>Specify)</i>		
on	ding th. : Afte	to	1 Accident 5 [☐ Pending investigation		Day Year)	Injury	М		<br Yes 2 🔲	No						
Division	To the Hospital or Attanding Physician: The lav within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:		Could not be determined	28e. Place of	Injury - At he etc. (Specif	ome, farm, sti	eet, factor	y, office		4	28f. Location (5 City or Tox			or Rural F	Route Numb) <i>97</i> ,
	ne Hospital 24 hours ne Funeral detely filled	edical (29a. Certifier 1 (Check only one)	Certifying Phy Medical Exem	sician: Te the be iner: Of the basis and hanner	s of examina	owledge, deat ition and/or in	h occurred vestigation	at the tim	ne, date an pinion, dea	nd place, a	and due to the e	cause(s) date and	and manne place, and	er as stat due to th	ed. ne cause(s)	
	To the within 2 To the comple	ž	29b. Signature and title	of certifier	111	/		296	c. License				29d. Date	e signed (N	Month, Da	y, Year)	
	/		•	4	7 hanh				OCMI	\equiv			Lan	uan	4 13	, 20	06
	h		30. Name and address of			of death (Item	n 23a) (Type,	Print)							1	*	
			Pamela 1		uthall	MD)	111	Penr	Str	eet,	Baltim	ore,	MD 2	1201		
ŀ	St Regist	ate rar	31. Date filed (Month, Da	ay, Year)	32. Regi	strar's Signa	ature	A. S									

Registrar

State

31. Date filed (Month, Day, Year)

JAN

DHMH 17 Rev 1/2001

ORIGINAL

32. Registrar's Signature

IMORE

			For State Registrar		State of Ma	•		tment of H		Mental Hy	giene Reg. No	dub	009	98
			Decedent's Name (First	st, Middle, Last)			. 1		2. Date of D	eath		3. Time of	Death
	Physici		Robert				N.	ndin	2	Januar	Da	y Year		75 AM
1	/Medic Examin		4a. Facility Name (If not in	nstitution, give	street and number)			4b. City, Town, or	Location of Dea		4	. County of Dea	-9	
			This John	is Ho	Phins 1	tospita	41	BAI.	finde	2				
	Funeral		5. Social Security Number		1	(In yrs. last birt		If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Bi	rth	9. Bi	irthplace (State o	or Foreign
	Director		218-76-78	394	0M 2□F	47	rs.	July 5	110010	01/15	/19	58		MD
	pur *		Usual Residence of Dece 10a. State 10b.	. County		10c. City, Town	orloca	ntion					10d. Inside C	ity Limits
	Maryla e ho	៦	NC	_										2 No
	28a-1	Director	10e, Street and Number	Dare		Avon		10f. Zip Code			10g Ci	tizen of What C	'ountor?	
	with ga or		40161 C C	Crav	Circle			27915				.S.A.	outly.	
	n 72 hours after death with the Maryland "natural", or Items 23s or 28s-f show walkst Extractional be notified at	Funeral	11. Marital Status	July	12. Was Decedent E	ver in U.S.	13. Wa	as Decedent of H	ispanic Origin? (Specify Yes or N		14. Race - Am	ierican Indian,	
0	r iter		1 Never Married 2	2 Married	Armed Forces? 1 ☐ Yes 2 1 No				ın, Mexican, Puè	to Rican, etc.)		Black, Wh	ite, etc.	
3	hours after lural', or ite	ठ्	3 ☐ Widowed 4 ☐ E	Divorced	tf Yes, Give Year or Dates:		1 1 1	Yes 2 No	Specify:			Specify: W	Thite	
2-0036	72 ht	Completed		Decedent's Edu ly highest grad		16a.	Deceder	nt's Usual Occup	ation during most of wo	orkina	16b. K	and of Business	s/Industry	
7	within 72 ene. then nai	du	Elementary/Secondary		College (1-4or 5+		life. DC	NOT use retired	1)	•				
V	led w lygier her ti		10	Adirector (and)		C	arp	enter	40. Made ada Na	man (Fired Adiabat)		rpentr	У	
and	be fi	Be	17. Father's Name (First,		·					me (First, Middle				
5	d Mer narke	ဥ	Norman Le			106	Madda	Address (Chant	and Number or R	a Mari				
<u>8</u>	d 2 sl		Camilla Oc		Sister		-		n Road,					
a)	s 1 end 2 should f Health and Mer item 27 ie merke other treumatic		20a. Method of Dispositio		DISCCI	20b. Place of	Disposit	tion (Name of	T.	Date		ocation - City o		
Ē	ages int of t: If it		1 X Burial 2 □ Cre 4 □ Donation 5 □ 0			(tory or other plac	1	/16 /06				
Baltil	permit. P Departme Importan any njur.		21. Signature of Emeral			Duran			m P∤x 01 ss of Facility (D 7\
n	Dep Impo		1/2	14					era Dri					
		-	23a. Part1. Enter the dis	ease, or comp	ications that caused t	he death. Do n							Approximat	te
	Physician		Immediate Cause (Final		ne cause on each line								Interval Bet Onset and	
	/Medical		disease or condition resulting in death)	-	w	consequence of							1 day	75
	Examiner				1.42		_	122					300	-
		ner	Sequentially list condition is any, leading to immedia	ale III	Due to (or as a	sequence o							Syca	4.1
	cuted nd ransi	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events		c									
Ď,	e exe ien a urial-1	EX	resulting in death) Last		Due to (or as a	consequence	of):							
0 9 1 9	the death certificate be executed y the ettending physicien and tched for use as the burial-transit	dical			d		_							-
٥	eath certific ettending p for use as	0	IF FEMALE:		10-14	,				-				
X Q Q	ath contract	an/	23b. Was decedent preg- in the past 12 month	Hant	23c. If yes, outcome o	Fetal death		ctopic pregnancy				23d. Date of de Month		Year
	at the de by the e	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4□Pregnant at t 9□Unknown	ime of death	5 LJ C	Other (specify)						
٦.	that ti ed by detac		Part II. Other significant	conditions co	ntributing to death but	not resulting in	the und	erlving cause give	en in Part I.	23e. Did	tobacco	use contribute	to the cause of c	death?
ecords,	S C 0	d by				•		, , ,		1 🗆	Yes 2	□No 3 11	Probably 4 🖂	Unknown
ဂ္ဂ	w require been signature	Completed								24a. Was		24h Wasa a	utona findings	avadabla
ĕ	has ge 2 :	d E								auto	psy ormed2	prior to death?	utopsy findings completion of c	ause ol
		င်	OF Was case relegand to	madical						1 ☐ Yes	2 1 No	1 ☐ Ye		
Vital	sicism: certific irector,	o Be	25. Was case referred to examiner? 1 ☐ Yes 2 ☑ No		Hospital: 1 Inpatien	t 2 ER/Out	nations	a DOA Othe	or	ath (Check only		a [] (2)		
Ö	ng Phys ter this neral di	-	27. Many or of Death		28a. Date of Injury (Month, Day		ime of	3 DOA 28c. Injun		Home 5 ☐ Res 28d. Describe			эсігу)	
DIVISION		atlon:	1 Matural 5 ☐ 2 ☐ Accident	Pending investigation	(Month, Day	Year) Ir	njury		k? Yes 2 ∐No					
NIS	Attendi r death. ector: A by the fu	if Co		Could not be determined	28e. Place of Injur	y - At home, lar	m, stree	it, lactory, office					Rural Route Num	nber,
בֿ	spital or At ours after o serel Direc filled in by	Certificat	4 El Florificiado	/	building, etc.	(эрвспу)				City or To	wn, State	3)		
	25 = >	edical	29a. Certifier 1 (Check only one)	Certifying Phy Medical Exami	sician: To the best of ner: On the basis of and manner state	examination and	, death o	occurred at the tin stigation, in my o	ne, date and plac pinion, death occ	e, and due to the urred at the time	cause(s date an) and manner a d place, and du	s stated. e to the cause(s	s)
	To the Ho within 24 To the Fu	Me	29b. Signature and title o	of certifier				29c. License				te signed (Mon		
	1		En	13	< MY.	2		RE	5-00	00	Tanı	acu. 1:	2,200	16
6	6		30. Name and address of	f person who c	ompleted cause of de	ath (Item 23a) (Type, Pr	rint)			-1114		7	
<u></u>)		Er Brik	er Joh	nsH pkins	Hospita	160	North	S-OC	reet Bal	Fim !	C. Mary	lord 21	287
	Sta		31. Date filed (Month, Da	ıy, Yəar)	82 Registra	's Sigrature								
	Registr		JAN	1 9 200	6 Second	, A.	400	(L)						
DΗ	MH 17 Rev 1/2	UU1				4	7							

ORIGINAL

			For State Registrar	State of Ma	aryland		rtment of tificate of		and Me		jiene	006	5 [0999	
			1. Decedent's Name (First, Middle, La					-	- 2	2. Date of Dea Month	th Day	Ye		3. Time of Death	Т
	Physicia /Medic		GWENDO LYN	^	JOBLE	Ē				TANUARY			6	04:13 AM	
	Examin		4a. Facility Name (If not institution, given			4b. City, Town, or Location of Death					4c. County of Death				
		•	Levindale Nur 5. Social Security Number 6.3		e (In yrs. lasi	t hirthday)	Baltin		24 Hrs 6	8. Date of Birth			Distribution	e (State or Foreign	
	Funeral Director			1 □ M 2 □ F 7. A9	70	Yrs.	Months Days		Min.	Month, Day	Year)	35	Country,)	,
	_		Usual Residence of Decedent		70					10 0		00	***		_
	ryland how	, [10a. State 10b. County		10c. City, T								10d.	Inside City Limits	
	e Ma Sa-f s	cto	MD NA		Ba.	ltim	ore							1 X Yes 2 □ No	
	ith th	Director	10e. Street and Number				10f. Zip Code				10g. Citîz	en of What	Country	?	
	s 23a		3314 Elgin Av	e	5	40.1		216	=:=2 (0===		1	U.S. 4. Race - A		Indian	
	itam Itam	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🔀	•	13. 1	Was Decedent of Yes, specify Cul	oan, Mexican	n, Puerto R	ican, etc.)			hite, etc		
936	urs af	by F	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1	I□Yes 20 No	Specify:				Specify:	Bla	ck	
21215-0036	ba filed within 72 hours after death with the Maryland tal Hygiena. id other than "naturel", or Itams 23a or 28a-f show avant, I're Medical Examinar must be notified at	Completed	15. Decedent's E (Specify only highest gr	ducation	1	16a. Deced	lent's Usual Occu	pation	t of working	7	16b. Kir	d of Busine	ss/Indus	stry	
21	iffin 7	nple	Elementary/Secondary (0-12)	College (1-4or	5+)	life. L	OO NOT use retir	ed)				-1 0		7.07	-
	a filed w al Hygier I othar th vant, In		12th grade	na			fits Sp						ecu	rity Ad	III .
and	ba fill Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name (First, Middle, Las	<i>t)</i>						(First, Middle,		oumame)			
Maryland	2 should ba and Mental Is marked o	T _o	Percy Rogers 19a. Informant's Name/Relationship	(Type Print)		19b Mailin	g Address (Stree			Bunde		Town Stat	e. Zin Co	ode)	
Σ	nd 2 s lith ar 27 is r trau		John Noble-Son				Ruth,						.,,	,	
re,	permit. Pagas 1 and 2 should Department of Health and Men Important: If Item 27 Is marks any in Jury or other traumatic once.		20a. Method of Disposition		20b. Plac	e of Dispos	sition (Name of natory or other pla	!	Da			cation - City	or Town	, State	
E	Paga ient o nt: If		1X Burial 2 □ Cremation 3 ['4 □ Donation 5 □ Other (Speci			-	n Star		/6/2	006	Bal	timo	re,	Md	
Baltimore,	partir porta y inju		21. Signature of Funeral Service Lice	insee	1	22 M	Name and Addr	ess of Facilit	y C+						
m	88 = 8		Maryon	X	apas	n 4	300 Wal	bash	Ave,	Balti	mor	e, M	d	21215	- 1
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused one cause on each li	d the death. I	Do not ente	er the mode of dy	ing, such as	cardiac or	respiratory arr	est,		In	oproximate terval Between	
	Physician		Immediate Cause (Final disease or condition	a. CORCNA	nu A	RTEM	1 DISEA	SE.						nset and Death	
	/Medical Examiner		resulting in death)	Due to (or as	a consequer	nce of):									
Ł		er	Sequentially list conditions	b. LEF7 Due to (or as	ATRIA a consequer		YXOMA						1	413	-
	utad I Insit	min	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	2/11			cis						24	irs .	
Ć,	exact In and ial-tra	Examin	that initiated events resulting in death) Last	c. Due to (or as			313						1		
8760,	The law requires that the death certificate be executed tie has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	dlcal		d											
9	ntifica ng ph s as th	a)	IF FEMALE:						-		-				
Вох	eath certific attending p	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Fetal de	ath 3	Ectopic pregnan	су			2	3d. Date of Month	delivery Da	v Year	1
0.	the a	Physician/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	t time of deat	h 5∟	Other (specify)							,	
<u>α</u>	that the detached		Part II. Other significant conditions	contributing to death b	out not resulting	ng in the ur	nderlying cause g	ven in Part I.		23e. Did to	bacco us	se contribut	e to the d	cause of death?	
ds,	uiras n signa ld be	d by								1 🗆 Y	es 2	No 3[] Probabl	y 4 □Unknown	
COI	w requires baen si should	ompleted								24a. Was a		24b. Were	autopsy	findings available	,
Re	The lavate has	E O								autops perfor	sy med 7 2. W No	death	to compl n? Yes 2[etion of cause of	
Vital Records,		Se C	25. Was case referred to medical					26. Place	of Death	(Check only or			100 20		_
of V	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatie	ent 2 EP	VOutpatien	t 3 DOA	her: 4 Nu	irsing Hom	e 5 🗆 Resid	ence 6	Other (S	Specify)		
n o	p je e		27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of Inju (Month, Da	iry Year) 28	3b. Time of Injury	W			Bd. Describe h	ow injury	occurred			
sio	at at a	cati	2 Accident investigation 3 Suicide 6 Could not	08]Yes 2□		3f. Location (S	tront and	Alumbasa	- Cural C	auta Alumbas	_
Division	or Attendir after death. I Diractor: Af d in by the fu	Certification:	4 Homicide determine	building, et	tc. (Specify)	a, rarm, str	eet, factory, office	•	20	City or Tow		TABILIDET OF	nulain	oute ivumber,	
_	To tha Hospital or Atter within 24 hours after de of the Funaral Diracto completely filled in by the		29a. Certifier 1 Certifying P	hysician: To the best	of my knowle	edge, death	occurred at the	ime, date an	id place, ar	nd due to the c	ause(s)	and manne	r as state	nd.	-
	a Hos 24 h a Fur letely	Medical		miner: On the basis of and manner st	of examination										
	To th within To th comp	Me	29b. Signature and title of certifier	۸			29c. Licer	se number		2	9d. Date	signed (M	onth, Da	y, Year)	
	N		Donna M.	Everily -	m.D.		Do	5473	9	J	ANUA	ary +	th 2	006	
	9		30. Name and address of person who	completed cause of o	death (Item 2	3а) (Туре,	Print)			-					
	(2434 W. Belve	deie Ave	, Ba	Itima	ore, M	aryla	nd	2121	5				_
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registr	ar s Signatur	100	Print) OPE, M								

			For State Registrar			d / Depa	artment of H	lealth and	-	_	01000
	Physicial		1. Decedent's Name (First, Middle, Las						2. Date of De	Day Year	3. Time of Death
	Physici /Medic			Marion E		lewton			Jami	my 13 1ttl	
	Examin	er	4a. Facility Name (If not institution, give				4b. City, Town, or		th	4c. County of Dea	
			Baltimore Washir			Jenter	Glen B		8 Date of Bir		rundel
	* Funeral Director			⊔м 2 ∑ F	76	Yrs.	Months Days	Hours Min	. (Month, Da	20, 1929 Ma	thplace (State or Foreign puntry) ryland
	riand Now		10a. State 10b. County		10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	the Marylar 28a-f chow	ctor	Maryland Anne Ar	undel	G	Glen Bu	rnie				1 ☐ Yes 2X☐ No
	after death with the Maryla or Itema 23a or 28a-f ehor Tiner must be notified at	Dire	10e. Street and Number	D .			10f. Zip Code			10g. Citizen of What C	ountry?
	a 23a	ral	7355 East Furn	ace Branc			210		Sanathi Van as Ni	U.S.	don Indian
-> .a	ter de	Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces	?	.5.	Vas Decedent of H f Yes, specify Cuba	an, Mexican, Pue	to Rican, etc.)	Black, Whi	
377A	al', or	by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:			∏Yes 2½ No	Specity:		Specify: Wh	ite
5 %	72 ho netu	eted	15. Decedent's Ed (Specify only highest grad	ucation de completed)		16a. Deced	lent's Usual Occup kind of work done o OO NOT use retired	ation during most of wo	rking	16b. Kind of Business	/Industry
121	within 72 hours after death with the Maryland ene then "natural", or itema 23s or 28s-f show the Medical Examinar most be notified at	ldm	Elementary/Secondary (0-12) 9th	College (1-4or	5+)		house Su			Mai1	
→ 12 p	filled Hygi other	e Co	17. Father's Name (First, Middle, Last)					18. Mother's Na	me (First, Middle	, Maiden Sumame)	
yland	ould be Mental Mrked c	To Be Completed by Funeral Director		lenry A. S	ander	,			ion Milh		<u></u>
Mary	1 and 2 should Health and Mer Is marke		19a. Informant's Name/Relationship (7 Richard Newton /				g Address <i>(Str</i> eet : Falls Roa			er, City or Town, State, Maryland 2	
HALC more,	ges 1 an it of Heal if item 2 or other		20a. Method of Disposition 1 Burial 2 Cremation 3	Dames of from State	20b. P	lace of Dispo	sition (Name of natory or other place	ca)	Date	20c. Location - City or	
Fi	Pag ment ant: i		4 Donation 5 Other (Specify				Crematory		3/2006	Baltimore,	
Salt Balt	permit. Pages 1 Depertment of h important: if ite eny injury or ot		21. Signature of Funeral Service Licen	See .	,	//				neral Servi timore, Mar	-
			23a. Part1. Enter the disease, or confi- shock, or heart failure. List only	lications that cause	d the death						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Ne cause on each		non	•				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a conseq		1	~ /		D '	
	LAGITIME	1	Sequentially list conditions,	b. Que to for as	MC T	165th	ctive	Mon	wany o	tislase	
1h	uted 1 Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (0. 41		action oil.			-		
6	te be executed ysician and e burial-transit	Еха	that initiated events resulting in death) Last	Due to (or as	a conseq	uence of):					
8760,	A > 0	dical	(d							
9 ×	eath certificat attending phy I for use as th	/Mec	IF FEMALE:	23c. If yes, outcome	of pregna	IDCV					
Bo	eath atten	clan	23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{Yes} 2 \subseteq \text{No} \)	1 Live birth 4 Pregnant a	2 Feta	Ideath 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	Day Year
P.O. Box 68	t the d by the tached	by Physician/Med	9 ☐ Unknown	9□ Unknown							
Division of Vital Records, F	n requires that the death been signed by the atte should be detached for		Part II. Other significant conditions co	ontributing to death I	but not resi	ulting in the ur	nderlying cause give	en in Part I.	. \	obacco use contribute to Yes 2 □ No 3 □ P	the cause of death?
ō	aw red s beer 2 shou	Completed							24a. Was	an 24b. Were a	utopsy findings available
8	The law sete has page 2 :	mo							auto perfo	rmed? death?	completion of cause of 2 ☐ No
/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?						ath (Check only		
of \	Physic this c	2	1 Yes 2 No	Hospital: Inpati		ER/Outpatien		4 🗀 (4015)(19)		dence 6 Other (Spe	cify)
u c	nding Physician: th. : After this certifice s funeral director, s	tlon	1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ay Year)	28b. Time of Injury	28c. Injun Worl	yat k? Yes 2 □ No	280. Describe	how injury occurred	
İSİ	Atten r deat sctor: by the	ifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of In	jury - At ho	ome, farm, stre	eet, factory, office		28f. Location (Street and Number or R	ural Route Number,
امّ	safte safte si Dire	Certification:	4 Homicide determined	building, e	tc. (Specify	v)			City or To	wn, State)	
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as it	edical	29a. Certifier (Check only one) Certifying Phyone) Check only 2 Medical Example 2 Certifying Phyone 2 Cert	ysician: To the best iner: On the basis of and manner st	of examina	wledge, death tion and/or inv	occurred at the ting restigation, in my o	ne, date and plac pinion, death occ	e, and due to the urred at the time,	cause(s) and manner as date and place, and due	s stated. to the cause(s)
	To th withir To th comp	ž	29b. Signature and title of certifier				29c. License	e number		29d. Date signed (Mont	h, Day, Year)
			Antra	MD			1)4	3977		January	13 2006
	'}		30. Name and address of person who o	completed cause of	death (Item	23a) (Type,	Print)	Von Bris	me. O	110.210	lot.
. €	Sta		31. Date filed (Month, Day, Year)	32. Regist	car's Signa	ture	APP	VICT (P PP		V VIII	-
	Registr	ar .	JAN 1	2006	Parlane .	. B.	6334				